The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Western Australian Branch

Royal Australian and New Zealand College of Psychiatrists
Discussion Paper, Justice and Mental Health Roundtable
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Management of mental illness in custody, diversion and solutions

Acknowledgement of Country

We acknowledge and respect Aboriginal peoples as the state's first peoples and nations and recognise them as traditional owners and occupants of land and waters in Western Australia.

We acknowledge that the spiritual, social, cultural and economic practices of Aboriginal peoples come from their traditional lands and waters, that they maintain their cultural and heritage beliefs, languages and laws which are of ongoing importance, and that they have made and continue to make a unique and irreplaceable contribution to the state.

We honour and respect their Elders past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

Acknowledgement of Lived and Living Experience

We recognise those with lived and living experience of mental health challenges and distress, their chosen families, moort, whanau, carers and kin. Their contributions, diverse perspectives, insight and courage keep us grounded and inclusive and focused on humanity, feeling and hope. We strive to work in genuine partnership in all that we do, honouring their voices by centring their experiences and expertise.

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation responsible for training and maintaining professional standards of medical specialists in the field of psychiatry in Australia.

Our roles include support and enhancement of clinical practice, advocacy for people affected by mental illness and it plays a key advisory role to governments on mental healthcare.

The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a binational college, has strong ties with associations in the Asia and Pacific region. The RANZCP has over 9,600 members, including more than 800 psychiatrists and those training to qualify as psychiatrists in Western Australia.

The RANZCP Western Australia Branch Committee partners with people with lived experience, including through an active partnership on our Branch Committee.

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Executive Summary

Western Australia's forensic mental healthcare is in a state of chronic, systemic failure.

For over three decades, the state's sole secure forensic psychiatric facility, the Frankland Centre at Graylands Hospital, has remained capped at just 30 inpatient beds. Meanwhile, the adult prison population has more than tripled. Acutely unwell individuals, many of whom are legally mandated to receive clinical care, are instead left languishing inside correctional cells.

Compounding this crisis, prison-based Crisis Care Units have devolved into sterile, untherapeutic containment spaces driven by risk mitigation rather than clinical care. Chronic workforce shortages leave prison healthcare staff overwhelmed, forcing clinicians to prioritise immediate self-harm triage over comprehensive, long-term treatment and support.

This system-wide failure disproportionately impacts vulnerable cohorts, including Aboriginal people and youth in detention. Prison populations are typically the most at-risk members of our community many of whom face pre-existing mental health issues but access mental healthcare for the first time only once they are in prison.

This discussion paper establishes that the current operational model is legally unsustainable, inefficient, and fundamentally incompatible with human rights and obligations of health professionals to their patients. It is intended to inform conversations about potential solutions and advocacy to the State Government.

Prisoners have a right to mental healthcare at least equivalent to that available in the general community. Key principles dictate that if acute mental illness requires involuntary treatment, it must be performed in hospitals, as prisons inherently lack the therapeutic environment required for recovery.

The WA Government, in collaboration with non-government stakeholders, must immediately intervene to:

- Resolve the forensic beds bottleneck
- Rectify the clinical workforce deficit
- Introduce a contemporary mental health system in custodial environments
- Humanise custodial crisis infrastructure
- Expand judicial diversion and transformative justice pathways
- Identify measures that prevent people with complex mental health issues from entering the justice system
- Fund adequate step-down services and supported accommodation.

Introduction and context

Statement of Intent

This discussion paper synthesises justice system data, legislative updates and clinical evidence to outline key issues and an actionable pathway out of the current gridlocked correctional system. The current state of forensic healthcare is alarming, and both infrastructure and staffing demand immediate reform. The RANZCP WA Branch has made consistent approaches to the government stakeholders providing evidence-based advice in support of systemic change.

The Convergence of Justice and Clinical Care

The intersection of the criminal justice system and the mental healthcare sector represents a complex public policy challenge in WA. Prisons have become default mental health institutions at the time of a policy shift towards community-based solutions. Prisons remain, however, structurally and operationally ill-equipped to provide adequate mental healthcare.

Best practice models in forensic mental healthcare are associated with a reduction in reoffending, one of the main tasks of the criminal justice system. Forensic mental healthcare must be provided in environments where clinical staff possess the autonomy and resources to treat the condition. When a state fails to provide this environment, the justice system ceases to function as a mechanism for rehabilitation and becomes a driver of institutional trauma.

The Imperatives for Reform

Under international human rights standards, prisoners retain an absolute right to a standard of healthcare that is at least equivalent to that available in the wider community. The equivalence principle is recognised in the United Nations' Standard Minimum Rules for the Treatment of Prisoners, the Principles for the Protection of Persons with Mental Illness, and the Convention on the Rights of Persons with Disabilities.[1] Leaving acutely unwell individuals in solitary confinement or sterile observation cells due to lack of hospital beds or supported accommodation, is an ongoing breach of the state's duty of care.

Investing in a robust, community-to-custody step-down framework is a clinical and social necessity that will reduce recidivism, alleviate pressure on the prison budget, and ensure a safer community.

Clinical Infrastructure and System Capacity in Prisons

Secure Forensic Bed Deficits

The foundational barrier to delivering equitable mental healthcare is the critical deficit in secure forensic hospital beds. The State Forensic Mental Health Service operates out of the Frankland Centre at Graylands Hospital, which has remained capped at an operational capacity of just 30 beds since it opened in 1993. Over this same period, the adult prison population has more than tripled.

The Office of the Inspector of Custodial Services (OICS) in 2018 estimated that approximately one third of all prisoners who were formally deemed so acutely unwell that they required involuntary admission under the Mental Health Act 2014, were never admitted to the Frankland Centre.[2]

WA currently has 2 forensic beds per 100,000 population,[3] which is well below acceptable clinical benchmarks.[4] This situation effectively forces forensic clinicians to ration acute care, prioritising only those individuals presenting with immediate, catastrophic risk to life.

The Criminal Law (Mental Impairment) Act (CLMIA) 2023 was designed to modernise how the justice system manages individuals with a mental impairment who are unfit to stand trial. The legislative framework is entirely unfeasible, however, without the physical infrastructure to support it.[5]

The State Government is committed to the Graylands Campus redevelopment which will provide significantly higher capacity. With major delays to construction, however, there are no transitional arrangements or alternatives for current mental healthcare requirements in prison.

Inequity in Forensic Crisis Care

Independent OICS inspections of correctional Crisis Care Units evidence the following major system pressures:

- Clinical Care Units are functionally designed as high-monitoring, risk-mitigation isolation blocks rather than clinical healing environments.
- Prisoners who are at highest priority rating with a serious psychiatric condition requiring intensive or immediate care, cycle in and out of crisis care centres, where staff otherwise struggle to provide the care required with exceptionally limited resources.[6]
- Severe workforce shortages across the correctional system include psychiatrists, mental health nurses, and psychologists, with over 1 in 5 healthcare positions sitting vacant.[7]
- Regional prisons provide little to no infrastructure dedicated to people in crisis. ‘Safe’ cells and ‘multi-purpose unit’ cells that are available, were never designed to support prisoners in crisis.

Legislative Realities and Structural Roadblocks

Despite the intent of the CLMIA to pivot away from indefinite, punitive detention towards structured and therapeutic pathways, the state lacks dedicated clinical infrastructure to support individuals in the community. This leaves the courts with no viable options than to

continue to hold individuals deemed ‘mentally impaired’ under CLMIA inside maximum-security prisons.

To bridge this gap, WA must treat forensic infrastructure expansion as a core health mandate that requires further capital investment from the State Government.

Impact on Key Populations

First Nations Overrepresentation and Cultural Safety

First Nations people are heavily overrepresented in WA prison system, accounting for about 39% of the adult prison population despite making up about 3% of the state’s total resident population.

While this remains a national concern, WA records the highest incarceration rate in Australia.[8] First Nations people make up 7% of youth population in WA aged between 10 and 17, but 59% of those under community supervision and 62% of those in detention.[9]

First Nations inmates face highly complex health needs, with 43% having a history of mental health conditions when entering prison.[10]

Coronial inquests and studies have consistently identified the lack of culturally safe health services as a major concern, pointing to substandard care and supervision in certain suicide cases.[11] The long-standing recommendations of the Royal Commission into Aboriginal Deaths in Custody remain to be implemented more than three decades later.

Youth Justice Gaps and Developmental Vulnerability

The intersection of developmental vulnerability, psychiatric morbidity, and the juvenile justice system represents a distinct clinical crisis. Approximately 65%of the juvenile detention population presents with significant mental health, neurodevelopmental, and/or cognitive impairments. This is a rate triple that of the general adolescent community.[12]

Despite this, youth forensic specialised infrastructure remains profoundly inadequate until the completion of the new Banksia Hill facility and the Djin-Djabi Crisis Care Unit. Similarly, WA has no forensic youth beds until the completion of the Graylands redevelopment.

Intellectual Disability and Co-occurring Morbidities

A major compounding factor in both adult and juvenile populations is the high prevalence of intellectual disability and complex co-occurring conditions such as severe substance use disorders. A landmark Human Rights Watch study revealed that approximately 60% of all individuals who died in custody had a diagnosed disability, with psychiatric conditions and cognitive impairments heavily overrepresented.[13]

Individuals with cognitive impairments are highly vulnerable to institutional sanctions, behavioural victimisation, and social isolation. OICS tracking reports note that over 55% of internal ‘behavioural incidents’ involve prisoners with a documented mental health condition or intellectual impairment despite this group comprising a much smaller fraction of the general prison population.[14]

The systematic failure to provide distinct, highly structured sub-acute units for vulnerable prisoners means the state frequently uses long-term segregation as a default management too. This fundamentally breaches the core principle of clinical equity.

Transitional Housing and Community-Based Rehabilitation

The Post-release Gap and Institutional Recidivism

The period immediately following release from a correctional facility represents a phase of acute clinical vulnerability for individuals with complex psychiatric conditions. Without a structured, medically supervised transition, the abrupt cessation of the structured custodial environment frequently leads to a severe fragmentation of psychiatric care. The clinical gap is a primary driver of institutional recidivism, cyclical homelessness, and elevated rates of post-release mortality, including accidental overdose and suicide.

Evidence-Based Community Rehabilitation Models

A dedicated network of forensic supported accommodation models with wrap-around support services is needed. These models would function as a vital step-down mechanism between maximum-security custodial environments and independent community living.

Under current funding frameworks, localised community care unit step-down residential services allow individuals with complex needs to stay for 6 to 18 months before returning to the community. However, these programs lack a dedicated forensic stream leaving a massive gap for patients exiting custody.

A robust framework must incorporate a stepped model of care tailored to varying levels of clinical risk, impairment and patient needs, integrated with comprehensive community support services, including access to Step Up/Step Down services currently in the community and the Aboriginal Community Controlled Health Organisations.

To ensure long-term stability and clinical continuity, these integrated services must deliver three core components, apart from adequate accommodation:

- Assertive community treatment partnerships
- Dual diagnosis and psychosocial rehabilitation
- Cultural wraparound support.

Diversion and Transformative Justice Pathways

Restructuring the Entry Point: Clinical and Judicial Diversion

Ideally, robust diversion pathways should be implemented at the earliest possible point of contact with the justice system. A sophisticated clinical diversion framework requires:

- Pre-arrest police response teams, such as the current Police/Mental Health Co-response program.
- Specialised mental health courts, such as a scaled AOD and Mental Health Diversion Program within the Magistrates Court. Magistrates must be empowered to mandate clinical treatment, therapeutic oversight, and community support as a direct substitute for bail or custodial offences for non-violent crimes.
- Expanding declared places under the CLMIA: non-custodial, secure residential facilities are required to allow the Mental Impairment Review Tribunal to safely oversee individuals in therapeutic, community-integrated settings rather than maximum-security jail cells.

Multiagency Interventions in Youth Justice

The imperative for diversion is magnified within the youth justice space, particularly given the ongoing operational instabilities impacting vulnerable cohorts. The WA Commissioner for Children and Young People details a compounding pattern of declining youth mental health and systemic gaps in early intervention programs. Left unaddressed, these issues funnel neurodivergent and traumatised children into punitive environments.[15]

Youth justice requires a child-centred, trauma-informed approach that treats behavioural escalation as a clinical or developmental symptom rather than a criminal choice. Therapeutic diversion must be driven by integrated, multi-agency funding models:

- Expanding high-impact early intervention projects
- Integrating one stop youth mental health hubs

Youth justice should be managed separately from the general corrective services environment, which requires a redesign of infrastructure and expansion of relevant mental health and social services.

Transformative Justice and Structural Reinvestment

Transformative justice moves beyond conventional models by acknowledging that crime is often underpinned by systemic social inequities, untreated mental illness, and structural institutional failures.

In the context of the justice system, applying transformative justice approaches requires a fundamental shift in budget allocations towards non-custodial approaches and a multi-faceted approach.[16]

The Kimberley Juvenile Justice Initiative is an example of a transformative justice project which includes programs led and delivered by Aboriginal Community Controlled Organisations, on-country alternatives to detention, and justice reinvestment models such as Olabud Doogethu project in Halls Creek.

Social Reinvestment WA has developed a comprehensive evidence-based blueprint for an application of transformative justice approaches to youth justice in Western Australia.[17]

Conclusion and recommendations

This discussion paper is intended to inform constructive discussion on shared strategies to improve mental healthcare across the justice system in Western Australia. It highlights the urgent need for government, clinical, legal, Aboriginal community-controlled, lived experience, non-government and service-sector partners to work together on practical reforms to drive improvement in the criminal justice system

The direction of these reforms should reduce reliance on custody, strengthen therapeutic care, and ensure people with mental illness, cognitive impairment and complex needs receive timely, culturally safe and clinically appropriate support.

The issues outlined require coordinated action across health, mental health, corrective services, youth justice, housing and community services, with a clear focus on prevention, diversion, treatment, rehabilitation and recovery.

The RANZCP WA Branch recommends the following reform measures for further discussion and approach to Government:

- Urgently expand secure forensic mental health bed capacity, including interim measures ahead of the Graylands redevelopment, to ensure people requiring hospital-level care are not left in custodial settings.
- Develop a funded forensic mental health workforce strategy across prisons, courts, hospitals and community services, including psychiatrists, mental health nurses, psychologists, Aboriginal mental health workers and peer workers.
- Replace custodial crisis containment models with therapeutic, clinically governed crisis care environments that meet mental health, human rights and cultural safety standards.
- Expand culturally safe, Aboriginal-led and community-controlled mental health and justice responses, including justice reinvestment, on-country alternatives, and culturally appropriate care pathways for people in custody and after release.
- Strengthen youth justice diversion and early intervention through trauma-informed, developmentally appropriate, multi-agency models that address mental illness, neurodevelopmental disability, cognitive impairment, family needs and social determinants of health.
- Scale up judicial and clinical diversion pathways, including police mental health co-response, specialist court programs, declared places under the CLMIA, and community-based alternatives to custody for people with mental impairment.
- Fund dedicated forensic step-down accommodation and supported rehabilitation services, integrated with assertive community treatment, dual diagnosis care, psychosocial support and culturally safe wraparound services.
- Establish transparent cross-agency governance, data collection and public reporting to monitor access, outcomes, workforce capacity, wait times, transfers to hospital, and progress against reform commitments.

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