COMPULSORY PSYCHIATRIC TREATMENT IN PRISONS: THE ARGUMENTS AGAINST

Background

Current resource constraints in Victoria mean that unwell prisoners generally wait longer and are sicker at admission to hospital than would occur in the community setting. Due to concerns about this, the submissions to the 'Royal Commission into Victoria's Mental Health System' of both Forensicare and the AMA have advised the State government to consider introducing compulsory treatment in prison under the *Mental Health Act 2014*.

The case generally advanced in favour of compulsory treatment in prison is a pragmatically driven one reflective of the need to relieve the distress of severely ill patients along with prevention of further deterioration in the patient's condition. It is also driven by the recognition that the release of seriously mentally unwell patients into the community from prison imposes a considerable burden on already severely under-resourced mainstream mental health services.

Since Thomas Embling Hospital opened in 2000, the prison population has increased by more than 150%, whilst the number of inpatient beds available at Thomas Embling has increased by only 15% in the same time. Further compounding this failure to keep pace with prisoner numbers, has been a disproportionate increase in prisoners who have a serious mental illness and the greater pressure on area based inpatient units.

Most public psychiatrists actually providing treatment in Victorian prisons however firmly oppose compulsory treatment in prison and the RANZCP has a formal Position Statement opposing such practice (https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/involuntary-mental-health-treatment-in-custody). This position has been strongly endorsed by forensic consumers in Victoria (see below).

This brief document summarises the key concerns regarding the practice. In preparing this, we note that the Terms of Reference for the Royal Commission include the statement:

"In formulating your recommendations you may have regard to any matters you consider relevant, including:

- *the evidence of people with lived experience…;*
- *the evidence of people from the mental health workforce who are engaged in preventing, responding to and treating mental illness…;*
- *the need to address stigma associated with mental illness including problems of knowledge, attitude and behaviours towards people living with mental illness…; and*
- *the need to safeguard human rights, promote safe and least restrictive treatment and ensure the participation of people with lived experience in decision-making that affects them."*

Tensions between Correctional and Clinical priorities,values and ethics

There is an irreconcilable tension between the purposes and priorities of a prison, and the purposes of compulsory treatment. The key functions of a prison include *punishment* of offenders and the deterrence of crime by way of deprivation of liberty in a secure setting. Mental health care has the *treatment and recovery* of individuals living with mental illness as its primary objective : punishment has no place in contemporary, humane health care. Simply put, the former prioritises use of physical and procedural measures to maintain control and the latter prioritises relationship- building to promote autonomy. As such, the culture and mindset inculcated in a custodial as opposed to a health system has profound implications for the perception of and response to distress, disturbance of behaviour and risk. This irreconcilable difference of underlying values and priorities is important not simply at the level of abstract policy but, most importantly, at the clinical coal-face.

Legislative Considerations

Services providing coercive psychiatric care within the context of prisons, which are inevitably fundamentally governed by correctional policies and philosophies, will never be able to do so in a way that complies with the core principles of the *Mental Health Act 2014*.

In the context of compulsory psychiatric treatment, the *Mental Health Act 2014* appropriately assigns ultimate responsibility for the application of restrictive practices to the Authorised Psychiatrist of a designated mental health service and sets careful limits around their application, in accordance with the clinical philosophy of a recovery-oriented approach to care in the least restrictive environment. Therapeutic concerns hold primacy. This ensures that any negative impacts on consumers of coercive treatment are mitigated, in line with contemporary care philosophies, including 'trauma-informed care.' The *Mental Health Act* has numerous provisions around the safe and humane delivery of care that protect the rights of mentally ill patients receiving compulsory treatment. These include:

- tight limits on the use of restrictive practices, and, if required, authorisation of such restrictive practices by the authorised/delegated psychiatrist responsible for the patient's care;
- mandated medical and nursing monitoring of patients in seclusion; and
- rights of access to family, carers and others.

Within Victorian prison environments, Corrections Victoria has responsibility for the safe care and management of prisoners within the constraints of the *Corrections Act 1986*. This dictates that, within the prison environment, Correctional staff hold ultimate responsibility for determining the applicability of restrictive practices, the nature of those restrictive practices and the manner in which those practices are implemented. The purposes of the *Corrections Act* with respect to prisons are to "provide for the establishment *management and security*[1] of prisons and the welfare of prisoners." In practice, the security concerns inevitably hold primacy over prisoner welfare. The current processes around restrictive practices within the Victorian prison system include:

[1] *Italics added.*

- placement of suicidal prisoners in stripped conditions in 'Muirhead' Cells;
- prolonged detention in segregation regimes on a 23 hour/day lockdown regime with minimal opportunity for meaningful activity;
- provision for use of physical restraints such as hand cuffs, body belts and even, on rare occasions, full body harness and spit hoods;
- on rare occasions cell extraction involving, if necessary, resort to use of plastic riot shields, tear gas, extendable batons and dogs to remove prisoners from cells; and
- tightly restricted access to family, carers and other supports.

These practices, implemented within the framework of the *Corrections Act*, are inimical to the aims of recovery-focused, trauma-informed clinical care and the principle of access to care of an equivalent community standard mandated by the *Mental Health Act*.

Patients of health services operating within prison environments, even those designated as 'mental health units', are inevitably fundamentally subject to the legal framework, culture, philosophies, values and practices of correctional services. Any attempt to safeguard rights under the auspices of the *Mental Health Act* would inevitably be trumped by the dominant correctional philosophical paradigm and legal framework.

The inevitability of the dominance of correctional approaches in hybrid models that attempt to implement involuntary treatment within prison environments, and the resulting dangers, have been well demonstrated in a recent coronial inquest in New South Wales[2].

An additional concern is that, despite the best intentions of all involved there will always be the risk of compulsory treatment in prisons over time being applied inappropriately in the management of "troublesome" prisoners.

Denying the rights to access equivalent care

Section 117 (a) of the *Mental Health Act* sets out the role of the Secretary of the Department of Health for the purposes of the Act, namely "to plan, develop, fund, provide and enable the provision of a comprehensive range of mental health services that are consistent with, and promote the objectives of, this Act and the mental health principles." One of these principles is that "persons receiving mental health services should have their rights, dignity and autonomy respected and promoted." One such right is articulated in section 22 of the Charter of *Human Rights and Responsibilities Act (Victoria) 2006*: "all persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person."

The prison environment is inherently traumatising, disempowering and counter-therapeutic for individuals suffering mental illness. The extension of a regime of compulsory treatment – which inevitably involves the traumatic imposition of enforced injectable medication in many cases – into such an environment would be wholly inconsistent with the human rights principles set out above, inimical to trauma-informed care and a step in the wrong direction for the longer term recovery of mental health consumers with complex needs.

[2] *https://www.theguardian.com/australia-news/2019/mar/08/nsw-corrections-apologises-to-family-of-david-dungay-for-custody-death*

Safety

From a practical perspective, there exist serious safety concerns about the provision of treatment for acute mental illness in a non-clinical, prison setting. Such treatment would in many cases require the administration of intramuscular sedating short acting forms of antipsychotics, with the concomitant risks of potentially life threatening side effects such as dystonias, hypotension and respiratory depression. Such risks are carefully and appropriately managed by way of observation and monitoring protocols in hospital environments.

In the Victorian prison environment, all prisoners are locked down in their cells overnight, with prisoner access only possible in the event of emergency, for example when it is thought that someone has attempted suicide. In reality, many mentally ill patients are in 23 hour lock down regimes, with minimal access to any form of meaningful activity. In such circumstances it is not possible to provide the regular nursing and medical observations mandated by the *Mental Health Act 2014* to ensure patient safety.

In the clinical scenario of needing to enforce administration of intramuscular medication, there is also the issue of who would physically restrain the patient if he/she is resisting. Given the responsibility of correctional authorities to ensure the safety of all staff and prisoners, it is expected that it would be correctional staff who hold the person down. The question is then whether or not the level of force used would be in accordance with the security-driven provisions of the *Corrections Act,* or the therapeutically guided provisions of the *Mental Health Act* and the Chief Psychiatrist's Guidelines around use of restrictive interventions.

Collusion with systemic failure to develop appropriate psychiatric treatment facilities:

Local experts, including those at Forensicare, have consistently advocated with government for the last 15 years around the need for long term planning for the provision of adequate forensic mental health services (including access to secure inpatient beds), given the anticipated growth in the prisoner population. We have concerns that acceptance of the practice of compulsory treatment in prison would remove the imperative for the funding and further construction by government of appropriate secure hospital beds and thereby consign the mentally disordered offender to enduring discrimination in terms of access to tertiary level hospital care commensurate with their level of clinical need.

The submission of the RANZCP Victorian Faculty of Forensic Psychiatry contains a range of proposals regarding high-quality, efficient future provision of forensic mental health services in Victoria.

The Perspective of the Prisoner with a Serious Mental Illness and the Impact on Therapeutic Alliance

The subjective, lived experience of consumers receiving compulsory treatment in a prison setting is unlikely to differentiate between the purposes of control and punishment by correctional authorities and the therapeutic purposes of compulsory psychiatric treatment. A mentally ill prisoner restrained by prison officers, injected with psychotropic medication (prescribed by a psychiatrist) and then held in a prison cell, would be very likely to come to

view mental health professionals as an extension of correctional authorities rather than therapeutically-focussed care providers.

This gives rise to concern that the possibility or implied threat of enforced medication within the prison environment would contaminate and damage the already challenging efforts of mental health professionals to work in a therapeutic and collaborative way with mentally ill prisoners. Prisoners talk to each other about their experiences with healthcare providers; such talk sets the 'cultural lens' through which health care providers are perceived. Prison psychiatrists work hard to ensure that prisoners understand their quite distinct role from that of correctional officers: fear of punitive sanctions is not part of the clinical relationship. Compulsory treatment within prisons would inevitably blur the crucial distinction between correctional and clinical staff roles and hence seriously jeopardise the trust that forensic consumers place in clinicians. This would in turn have seriously negative, potentially very risky, impacts on the likelihood of consumers disclosing symptoms and seeking help early in the event of deterioration in their mental health. The loss of faith in mental health clinicians would of course likely extend to community-based practitioners upon their release.

International norms and standards

Internationally, authorities have recognised for over 50 years that mentally unwell prisoners require treatment in hospital settings. Rule 82 (2) of the United Nations' 'Standard Minimum Rules for the Treatment of Prisoners'[3] states:

"Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management".

Similarly, the WHO Trencin Statement on Prisons and Mental Health (2007) asserts that:

"Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained".

and

"There must be a clear acceptance that penal institutions are seldom, if ever, able to treat and care for seriously and acutely mentally ill prisoners".

[3] *Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. See also United Nations, Human Rights and Prisons: A Pocketbook of International Human Rights Standards for Prison Officials New York and Geneva 2005, p 5:*
http://www.ohchr.org/Documents/Publications/training11Add3en.pdf and
http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2007/trencin-statement-on-prisons-and-mental-health

It is simply not possible to provide the same quality of recovery focused care and treatment in prison that can be provided within a secure hospital setting.

Consumer views

A leading local Forensic Consumer Consultant has eloquently summarised the views of forensic consumers, following a consultation process on this issue:

"… we need adequate dedicated specialist mental health services, the lack of them should not be an excuse to go down the slippery path of gazetting in prison itself. I concur with the RANZCP position statement 93 on this matter.
Treatment is more than medication, which can also run the risk of being used as chemical restraint in restrictive, controlling environments. Medication and other treatment forms should take place within a suitable therapeutic environment as a safeguard against abuse and to support and enhance effective, safe delivery of such treatments.
It is bad enough we take away someone's physical and environmental freedoms. We should not be allowed to do incursions into someone's mind as well in those circumstances, a very dangerous and blurry line to cross. Dealing with loss of freedom of movement is as much a mental exercise in coping as having to physically put up with containment and externally imposed restrictions.
The more relaxed therapeutic environment at places like Thomas Embling Hospital compensate and allow for more human rights based intervention in a consumer's mental activities, if we go down that path, with the hope of alleviating suffering for them.
Prison will only become an even more tempting option for dumping the mentally and criminally unwell, who have been dispossessed by a broken mental health system and the personal rejection of broader society, if we allow treatment in prisons. We need to repair our communities for all more than we need to single out, stigmatize and ostracize those who do not fit as we would like."

Summary

The Royal Commission into Victoria's Mental Health System was a response to growing concerns about systemic failure that has resulted in a fragmented, run-down, reactive and piecemeal approach to the delivery of treatment to the seriously mentally ill. The suggestion of compulsory treatment in custody merely promulgates this lack of a systems-based holistic treatment model. There is an urgent need for substantially enhanced access to acute care for severely and acutely mentally unwell offenders. The need is a compelling one that speaks to the ethical duty to provide care to forensic consumers. We also have a duty to advocate on their behalf. We believe however that it is not possible to provide safe, effective and ethical care on a compulsory treatment basis within the prison environment.

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