Involuntary mental health treatment in custody

November 2017

Position statement 93

Summary

Involuntary mental health treatment in custodial settings compromises clinical care, encourages inappropriate management of prisoners, and breaches human rights.

Purpose

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) opposes the use of involuntary psychiatric treatment for persons in custody. Due to the lack of alternative treatment models in some states and territories, there may at times be no other option for providing timely treatment to people in custody with severe mental illness. However, the RANZCP wishes to emphasise the urgent need for governments to provide alternatives, and the need to ensure that the risks of involuntary treatment in prison are properly understood by everyone who owes a duty of care to prisoners.

This position statement details the RANZCP's views and makes recommendations to ensure that prisoners receive mental health treatment in appropriate settings. While the position statement concerns psychiatric treatment, the RANZCP acknowledges similar concerns regarding involuntary physical treatment in custody, including the ability of custodial services to enforce examinations and treatment on prisoners.

Definition

Involuntary mental health treatment refers to psychiatric treatment provided without a person's consent. In Australia and New Zealand, this can be authorised by Treatment Orders made under Mental Health Acts (including Community Treatment Orders).The Acts establish principles and safeguards to ensure that involuntary treatment is administered by mental health services only as a last resort to prevent imminent harm to the patient or others, or to prevent serious deterioration in physical or mental health. One safeguard involves the duty of clinicians to assess whether patients have the capacity to make decisions about proposed treatments, and to provide support to help patients make those decisions.

Background

Incarceration rates in Australia and New Zealand have increased dramatically over the past decade[1] and many prisoners suffer from some form of psychiatric condition. Prisoners are 2 to 3 times as likely as those in the general community to have a mental illness and are 10 to 15 times more likely to have a psychotic disorder (Ogloff, 2015; Butler et al., 2006; World Health Organization, 2014). Custodial authorities face serious challenges when trying to manage prisoners who develop severe psychiatric symptoms. For this reason, custodial authorities in most Australian states and territories can order involuntary psychiatric treatment (Crimes Act (NSW) 1999; Corrective Services Act (Qld) 2006; Prisons Act (WA) 1981; Correctional services Act (NT); SA Health, 2014), but the laws allowing them to do so lack the safeguards found in the Mental Health Acts.

Human rights

Both correctional and health agencies have responsibilities in relation to prisoners, but they may have different perspectives on the best way to provide health care for those with mental illness. However, clear guidance exists in a range of policy statements and human rights instruments. Their fundamental principle is that prisons are not hospitals and should never be viewed as such. United Nations human rights instruments state that all individuals have the right to access health care appropriate to their needs regardless of their legal status. This is known as the 'principle of equivalence'. It is recognised in the *Standard Minimum Rules for the Treatment of Prisoners*, also known as *The Mandela Rules* (United Nations General Assembly, 2015), the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1991), and the *Convention on the Rights of Persons with Disabilities* (2008).

The principle of equivalence requires that prisoners be transferred out of prison if involuntary treatment is needed, to ensure they receive appropriate care with proper safeguards. The Mandela Rules state that prisoners 'diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons, and arrangements shall be made to transfer them to mental health facilities as soon as possible.' The World Health Organization supports this rule in the following terms: 'there must be clear acceptance that penal institutions are seldom, if ever, able to treat and care for seriously and acutely mentally ill prisoners' (WHO, 2007).

The *National Statement of Principles for Forensic Mental Health* was endorsed by all Australian Health Ministers and it affirms this principle: 'legislation should not allow coercive treatment for mental illness in a correctional setting' (Australian Health Ministers' Advisory Council, 2006). The Mason Report (the sentinel report underpinning forensic mental health services in New Zealand), made a thorough review of adverse mental health outcomes of people being treated in prisons. The report unambiguously stated, 'no general distinction should be made between offenders and non-offenders on the question of eligibility for treatment in hospital' (Ministry of Health, 1988) and this principle has been incorporated into the *Corrections Act 2006* (NZ).

Involuntary treatment in custody also compromises the 'principle of reciprocity'. This principle holds that society has no right to remove civil liberties from patients for the purpose of treatment if resources for that treatment are inadequate (Eastman, 1994; Fistein, 2009). If a prisoner experiences psychiatric symptoms so acute that involuntary treatment is needed, they should receive it from a specialist multidisciplinary team at a hospital; the care available in prison is not an adequate substitute.

Clinical practice

In order for Australia and New Zealand to comply with these principles, it is critical that prisoners suffering from mental illness can access the same quality of service or treatment as their nonoffender counterparts. This access is necessary to encourage recovery and self-care, and interventions tailored to the psychiatric and criminal justice needs of offenders have been shown to greatly reduce reoffending (Morgan et al., 2012). Given the over-representation of Aboriginal and Torres Strait Islander peoples and Māori in prison populations, special attention must be paid to their mental health needs to ensure equivalent mental health outcomes (Victoria Department of Justice and Regulation, 2015).

Currently, Australia and New Zealand are a long way from providing equivalent services. Media reports, Ombudsmen and coronial inquests have identified issues of concern, such as mentally ill prisoners facing waits of over a year for hospital beds (SMH, 2012), and inappropriate management of mentally ill prisoners (Victorian Ombudsman, 2014, 2015; Western Australian Ombudsman, 2000; Radio New Zealand, 2017).

Given the delays in securing hospital treatment, and the challenges of managing mentally ill prisoners, involuntary treatment in prisons may appear to be a pragmatic and cost-effective approach. However, this approach is not only a serious violation of human rights, it also has serious clinical implications.

When any treatment, including medication, is being administered involuntarily, multiple safeguards are needed (such as a diagnosis of mental illness and an assessment of the patient's capacity to make treatment decisions). The principle of equivalence requires that if involuntary treatment is necessary, it must be performed in hospitals to ensure that proper safeguards apply and vulnerable prisoners are not placed at risk of direct harm.

Several risks arise when these safeguards are not in place. Disruptive behaviour in prisons may be wrongly labelled as psychiatric illness and treated with inappropriate medication – which may be accompanied by inappropriate control and restraint practices and solitary confinement. The danger also exists that prison authorities may be more reluctant to transfer prisoners with genuine psychiatric conditions to mental health facilities. 'Despite

the apparent humanity of treating distressed mentally disordered people, the necessity of compelling treatment only in a hospital setting provides suitable immediacy that transfer may be expedited, lest otherwise it is terminally delayed while stopgap measures occur' (Sullivan and Mullen, 2012).

Even if the safeguards found in the Mental Health Acts were present, prison would not be an appropriate place to administer involuntary treatment, because the prisoner would not have access to mental health care that is equivalent to what a non-prisoner would receive. For this reason, the RANZCP also opposes the use of Treatment Orders for prisoners, unless they are used as a means to facilitate transfer out of prison to an appropriate facility.

Every delay in transferring people to hospital risks exacerbating acute psychiatric conditions. Ideally, beds will always be available in forensic mental health facilities on the basis of need, to prevent delays in treatment. When such beds are not available, however, involuntary treatment in prison should not be the default option. Depending on the jurisdiction, different alternatives may be suitable, such as specialist services that facilitate the early diversion of low-risk inmates from remand and prison to general mental health services, avoiding imprisonment altogether where possible. General mental health services can play a larger role in meeting the clinical needs of remandees and convicted offenders, although these services would need the capacity, the legal provision and the will to accept transferred prisoners for treatment if such treatment is to be timely.

Recommendations

- The RANZCP is committed to eliminating involuntary mental health treatment in custodial settings. Involuntary mental health treatment should only occur in appropriately designated mental health services, outside of custodial environments, that are appropriate to individual clinical and risk management needs.
- The RANZCP supports legislation that enables prisoners to be diverted into appropriate mental health settings if they are in need of involuntary mental health treatment.
- The RANZCP supports principles that promote equivalence of care for those with mental illness in the criminal justice system. Access to health care should not depend upon legal status.
- The RANZCP recognises that the prevalence of mental disorder amongst individuals in custody is much greater than amongst the general community and that mental health services need additional resources to respond to these clinical needs. Given the overrepresentation of Aboriginal and Torres Strait Islander peoples and Māori in prison populations, additional services to meet their needs are urgently needed.

[1] In Australia the prison population has increased from 25,400 in 2005 to 36,104 in 2015 in Australia. This demonstrates an increase in incarceration rates from 155 per 100,000 people in 2005 to 196 per 100,000 in 2015. In New Zealand the prison population increased from 6048 in 2002 to 8618 in 2012. This equates to an incarceration rate of 203 per 100,000 people. In New Zealand over 50% of prisoners are Māori and in Australia over 25% are Aboriginal and Torres Strait Islander peoples. In New Zealand only 15% of the population is Māori and just 3% of the Australian population is Indigenous (Australian Bureau of Statistics, 2015; Statistics New Zealand, 2012).

Responsible committee: Faculty of Forensic Psychiatry

References ›