



The Royal
Australian &
New Zealand
College of
Psychiatrists

Supplementary submission - Inquiry into the high level of First Nations people
in custody and oversight and review of deaths in custody
Changes required for conversion of enforced involuntary treatment from
Prison Settings to Hospitals – January 2021

Improving the mental health of the community

Introduction

At the recent hearing of the Select Committee into indigenous incarceration rates and indigenous deaths in custody, the Royal Australian and New Zealand College of Psychiatrists Forensic Faculty New South Wales Subcommittee (RANZCP, the 'College', or 'committee') was asked to provide on notice evidence of the changes necessary for conversion of enforced involuntary treatment in New South Wales (NSW) from Prison Settings to Hospitals. Specifically, what legislative or structural changes would be necessary, and what would a solution 'look like'.

The Committee has outlined these issues below, but we note that the College is not the writer of policy. Any implementation would of course be subject to policy review by the Ministry of Health, and appropriate implementation processes by the Local Health Districts involved. Because these changes relate to remanded prisoners, Corrective Services NSW would also be involved in the development of any solutions.

Treatment in custody

At present in NSW, enforced involuntary treatment is done in an area of the Long Bay Correctional Centre known as "Long Bay Hospital" (LBH). The College's longstanding position is against enforced (involuntary) mental health treatment in custody. The reasons are enunciated in position statement number 93 [1]. A review of the world literature on this topic has been published recently. New South Wales is the only state in Australia that allows this [2].

General Principles of approved models

- Indigenous people are impacted differentially by both Justice and Mental Health systems. Indigenous involvement must therefore be front and centre in development of mental health treatment services, as design by Corrections and Health alone is, and has been, wanting.
- Services in custody should be guided by the foundational ethical and moral principle of 'equivalence' – namely that services in prison are equivalent to what would be available in the community. This is enunciated in point 9 of resolution 45/111 of the United Nations Organization (UNO) of 14 December 1990 concerning the "Basic principles for the treatment of prisoners." This states "*Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation*"³. The principle of equivalence is also cited by the World Health Organization (WHO) in the context of the Health in Prisons Project, one of the strategic objectives of which is: "*to promote all prison health services, including health promotion services, to reach standards equivalent to those in the wider community.*"⁴ The RANZCP endorses this concept in the previously referenced position statement.⁵

¹ Royal Australian and New Zealand College of Psychiatrists. Position statement 93. Involuntary mental health treatment in custody (2017, November)

² Carroll A, Ellis A, Aboud, Scott R, & Pillai K No involuntary treatment of mental illness in Australian and New Zealand prisons. *The Journal of Forensic Psychiatry & Psychology*, 1-28. September 2020

³ <https://www.ohchr.org/EN/ProfessionalInterest/Pages/BasicPrinciplesTreatmentOfPrisoners.aspx>

⁴ https://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

⁵ *Ibid* 1

- Likewise, authentic consumer involvement is a crucial aspect of modern psychiatric practice [6]. One of the reasons that the College is not supportive of enforced treatment in custody is that prison-based models cannot accommodate this voice.
- Design of modern psychiatric units should reflect modern human rights principles, including the principle of equivalence as articulated by international standards [7]. Prison hospitals, including the prison environment of LBH as it currently stands, does not meet those standards.
- Design should reflect modern clinical standards for ethical, evidence-based care with long term outcomes, as well as immediate care in mind [8]. Design should reflect National Standards for Mental Health Services [9] and National Safety and Quality Health Service Standards [10]
- The capacity to admit correctional patients for involuntary treatment relies on a whole of system approach (part of a network of interventions) and simply providing this, in the absence of effective diversion, community, and correctional mental health care, is insufficient. This is relevant to both inpatients and outpatients. We note that the recent Federal Productivity Commission into Mental Health endorsed this and made particular mention of the potential benefits from investing into the mental health of people in the Criminal Justice System [11].
- Application of enforced involuntary treatment is a last resort. It should be applied according to the “least restrictive safe and effective” principle outlined in the *NSW Mental Health Act 2007 (section 68)*. or persons in custody this means that transfer only occurs if “*other care of an appropriate kind would not be reasonably available to the person in the correctional centre.*” The World Psychiatric Association has spoken out on the need to develop alternatives throughout the speciality of psychiatry.¹²

The Current Situation

During the oral hearing, there was some uncertainty about what Act of law detention of mentally ill people in prison came under.

The committees understanding is as follows: at present, LBH within Long Bay Correctional Centre has 85 bed/cells, all of which are “gazetted” under the *Mental Health Act 2007* as a “declared mental health facility”. This is described under Chapter 5, Part 2, Division 1, Section 109 (“Establishment of declared Mental Health Facilities”) of the *MHA 2007*.

However, the legislation is clear that the *Mental Health Act* is secondary in function to the *Crimes (Administration of Sentences) Act* within the facility. This is outlined in Sections 76 (C) and 76 (D) of the *Mental Health (Forensic Provisions) Act 1990*.

The committee understands, that in practice, 45 of these bed/cells have never been used for *Mental Health Act* patients. They are designated for general medical care and aged care.

⁶ Department of Health. National standards for mental health services 2010 available at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10>

⁷ United Nations. Standard minimum rules for the treatment of prisoners 2015, December

⁸ World Health Organization. Trencin statement on prisons and mental health October 2007

⁹ Department of Health. National standards for mental health services 2010

¹⁰ [Mental health | Australian Commission on Safety and Quality in Health Care](#)

¹¹ <https://www.pc.gov.au/inquiries/completed/mental-health#report>

¹² Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care. October 2020. Maria Rodrigues, Helen Herrman, Silvana Galderisi and John Allan. Available at https://3ba346de-fde6-473f-b1da-536498661f9c.filesusr.com/ugd/e172f3_a10897d3d4f546bc8a06a23629726ccf.pdf

A further 30 bed/cells house both forensic patients and transferred prisoners who are cooperative enough to take treatment without it being enforced. This is in a subacute area known as 'E and F ward'. The forensic patients are held under their orders for detention. The transferred prisoners are "correctional patients". They are held by both their status as remand or sentenced prisoners, and an order under the *Mental Health (Forensic Provisions) Act 1990*. Occasionally prisoners are placed in these cells purely by their status as a prisoner.

In the area of LBH known as 'G ward', there are 10 bed/cells with cameras. This is an acute area where, in practice, involuntary treatment in custody takes place. There are generally 5-10 people waiting for placement at LBH at any one time.

Forensic Community Treatment orders

In New South Wales, there is a form of involuntary treatment in the community via "Community Treatment Orders". These have their equivalent in custody, known as "Forensic Community Treatment Orders" (FCTOs). These are applied in custodial settings where a person cooperates with treatment. These are not in the scope of enforced involuntary treatment, except in the situation where a person refuses to cooperate with the conditions and requires transfer to hospital (LBH while in custody) to enforce or review the applicability of the order.

Females and young people of male patients, and Section 55

Currently, females and young persons do not receive enforced involuntary treatment in custody. There are no facilities gazetted as such in Youth Justice Centres. Historically the LBH Correctional Centre accommodated this practice for females, but does not do so any longer. Better bed management (outlined below) rendered the practice obsolete.

Females and young persons are almost always transferred to the Forensic Hospital, although there are examples of female patients who are in prison being admitted and treated in local units such as Concord Centre for Mental Health or Westmead.

This is possible under the *Mental Health (Forensic Provisions) Act 1990*. The relevant section is s55, particularly s55 (1)

Transfer from correctional centre by Secretary

(1) The Secretary may, by order in writing, direct that a person imprisoned in a correctional centre be transferred to a mental health facility.

(2) The Secretary may make a transfer order on the basis of 2 certificates about the person's condition issued by 2 medical practitioners, one of whom is a psychiatrist. The certificates are to be in the form set out in Schedule 2.

In this case "mental health facility" has the same meaning as it has in the Mental Health Act 2007 i.e. the legislation does not specifically dictate that male prisoners that are '*mentally ill persons*' under *MHA 2007* must go to Long Bay for enforced involuntary treatment.

The reason this is relevant is with respect to the Select Committee's request for an outline on what legislative changes would be necessary to end enforced involuntary treatment. The College notes that, as it stands, there is nothing in legislation preventing a prisoner (on remand or sentenced) deemed a '*Mentally Ill person*' under the *MHA 2007*, from being transferred out to any declared mental health facility. Indeed, this does, on occasion, happen. This is therefore also possible for male prisoners.

In the Committee's opinion there are several reasons this does not happen: including the availability of enforced involuntary care at Long Bay; the lack of alternative pathways; and the culture and practice, dictated by the first two realities, that means this does not happen. It also

means that there are no legislative changes required to end enforced care in custody, it can be done by de-gazetting the unit in which it happens.

Proposed solutions

The 45 beds that are part of the general medical bed/cells at the Long Bay Hospital should lose gazetted status. They are unsuitable, and not used, for any type of enforced involuntary treatment.

The 30 bed/cells in the mental health area of Long Bay where enforced involuntary treatment does not occur could lose gazetted status. Forensic patients housed there will continue to be reviewed under the *MH(FP)A 1990*.

As we understand it, if a person is cooperating with treatment, and is not requiring enforced treatment to be delivered, they could be managed on FCTOs or as voluntary patients in this unit with no change to current practice. If they are placed under the legal framework of an FCTO, this ensures the required oversight from the Mental Health Review Tribunal.

The key issue then becomes the alternatives that need to be developed for the 10 bed/cells where enforced medication takes place. A specific solution will be outlined below, but broadly speaking patients, after all ability to persuade them to take medications have been exhausted, will have to go to a gazetted unit in another hospital for treatment, as would happen with any other member of the community. Once an alternative is developed, this unit should then lose gazetted status. Developing an alternative will require recruitment and training, so there should be a graded changeover in the order of months.

The committee note that one potential solution is that there are 8 vacant, unstaffed beds at the Forensic Hospital (FH). If staffed appropriately they could admit the type of patients currently admitted to LBH. (It is worth noting that the patients currently in the Forensic Hospital were often managed at LBH prior to their transfer to the Forensic Hospital).

With effective bed management this could replace the need for the 10 bed/cell unit. As we have noted above, this approach currently works effectively for female and young persons (up to age 21) of both genders. It has been demonstrated overseas and in interstate units to be safe and effective [13].

Additional pathways

As we have noted above, this model should be part of a whole of State approach. The first aspect, as we outlined in our in-person evidence before the Select Committee, is the key role of enhanced, state-wide court diversion programmes in progressing this situation. Court diversion programmes are designed so that people get the mental health care they need – which should be culturally specific in the case of indigenous people – whilst ensuring that any legal processes can be ongoing.

The second aspect of this is that we have had anecdotal feedback from our colleagues in community mental health that mental health teams in local health districts are well aware that their patients are in the custodial system and that in many cases they would be willing to treat them as inpatients whilst also ensuring any legal obligations are met.

We believe, therefore, that a small number of appropriately risk assessed patients could be transferred to nearby Mental Health Intensive Care Units (MHICUs) for enforced treatment. Suggested units around the state may include Prince of Wales, Concord, Cumberland, Hornsby, Mater, Orange. This could be done with central coordination of the bed usage, in a

¹³ Adelugba O, Mela M, & Haq, I. Involuntary treatment of psychiatric inpatients certified under the Saskatchewan Mental Health Services Act in a secure forensic psychiatric treatment center. *Medicine, Science and the Law*, 2:55 p.113–120. March 2014.

network fashion. The Forensic Hospital would be part of this network and available if the risk was deemed to be unmanageable on any of these units. The management of appropriately assessed prisoners in general mental health units has been established as safe and effective in interstate jurisdictions [14]

One of the issues we have heard from our colleagues in community inpatient units is their understandable reluctance to accommodate prisoners if it requires the accompaniment of prison officers. The reasons for this are myriad but, in short, the presence of armed prison officers and a fellow patient handcuffed is not appropriate on an acute psychiatric unit.

There appears to be some confusion and conflicting anecdotes as to whether Corrective Services legally must stay with the patient should they be transferred to a local unit. We note that they do not do so when women, men and young people are transferred to the Forensic Hospital, due to the existence of a Memorandum of Understanding (MoU) between those two organisations. We therefore recommend the development of similar MoUs to the current one between Corrective Services NSW and TFH should be developed with the relevant Local Health Districts.

Development of First Nations Specific Pathways

Given treatment of mentally ill First Nations people is one of the specific purposes of the Select Committee, and that also any solution to these specific issues would benefit the overall throughput of patients, we feel it appropriate to mention. Briefly, the College of Psychiatrists is aware of the various issues regarding First Nations people in custody and the lower rate of diversion they receive at court. We are seeking to liaise with the representatives of some Local Health Districts, and the Aboriginal Medical Service, to try and develop First Nations specific diversion pathways. These discussions are at an early stage.

In line with the broader proposal outlined above, one potential option is having specific beds earmarked for Mentally Ill First Nations people who are diverted at court or from custody under s55 of the *MH(FP)A 1990*. There would obviously be limitations to such a proposed model, namely that psychiatric hospitals in the state are almost always at capacity, so the likelihood of a bed being 'free' is very low. Nevertheless we inform the Select Committee that we understand that this is one strand of the problem and we are keen to develop solutions to it.

Resourcing for proposals

Resourcing is generally an operational matter and therefore we would largely defer on this matter to the Health District responsible for implementing any change. Broadly, the college believe that should the Select Committee recommend staffing for the acute forensic beds to open the 8 TFH beds, and keep the 10 LBH bed/cells operating for voluntary treatment/FCTO prisoners or other prisoners staffing and ancillary services (meals, linen etc) would be between approximately \$2 - 3M annually for medical/nursing/allied health. This is based on current estimates for per person per night beds in the Acute Unit of the Forensic Hospital.

Of course, if the 10 bed/cells in LBH were no longer used for mental health patient/prisoners, then the cost of this might be defrayed to the proposed new model at the FH. Medical & nursing staff positions could move to TFH, and costs currently incurred at LBH could cover the remainder.

The RANZCP understands that beds at TFH (solely funded by health) are equivalent cost per day to those at LBH (jointly funded by health and CSNSW). If this is the case, and the function

¹⁴ Quinn C, Ryan J, Fullam R, & McKenna B. The Use of restrictive practices on males released from prison and entering acute mental health services: A retrospective cross-sectional comparative study. *Issues in Mental Health Nursing*, 7:40 p. 626-631. 2019.

NSW Branch Submission

Supplementary submission

Changes required for conversion of enforced involuntary treatment from Prison Settings to Hospital

of the 10 bed/cells is taken over by the 8 beds at TFH, then resourcing would not have to increase for this solution.

Summary

We hope the select committee finds this document helpful. The RANZCP is against enforced involuntary mental health care in custody. We are hopeful that the provisions for mentally ill prisoners in this state can be brought into line with what is available in other Australian jurisdictions. We endeavour to help in any way we can to develop solutions to these problems.