8 February 2021

Hon Adam Searle MLC
Committee Chair
Parliament House, Macquarie St
SYDNEY NSW 2000

Dear Sir,

Inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody

Thank you for your invitation to Legal Aid NSW to make further comment in relation to the evidence received by the Select Committee in public hearings held during December 2020.

Our response is detailed below and limited to commenting on evidence in the following sessions:

3 December 2020:	Australian Medical Association, and Royal Australian and New Zealand College of Psychiatrists.
7 December 2020:	NSW Police Force.
	Law Enforcement Conduct Commission.
	Department of Communities and Justice, Corrective Services NSW.
8 December 2020:	Justice Health and Forensic Mental Health Network.
	Inspector of Custodial Services.

Improved health care

Legal Aid NSW strongly supports the evidence provided by Dr Smith and Dr McMullen on 3 December 2020 in relation to improvements to health care for First Nations people, particularly mental health care in custody.

On behalf of the Australian Medical Association (**AMA**), Dr McMullen highlighted the correlation between imprisonment and poor health, indicating that

> "imprisonment can exacerbate and entrench the social and health disadvantages that contribute to imprisonment in the first place."

With regard to Aboriginal and Torres Strat Islander deaths in custody, Dr McMullen acknowledged that lack of access to appropriate healthcare is a significant factor in many Aboriginal deaths in custody. [1]

- The first recommendation of the AMA was to improve health service provision to Aboriginal and Torres Strait Islander people, specifically targeting mental health conditions, substance use disorders and cognitive disability, which are significant drivers of their imprisonment.

- The AMA further recommended support of culturally safe and comprehensive primary care and other health services, including those provided by Aboriginal community-controlled health organisations.

- The final recommendation of the AMA was that NSW adopts workforce targets to increase employment of Aboriginal health workers and health professionals in prison health services to support them to deliver a culturally competent health service.

All these recommendations are consistent with Legal Aid's position and the contents of our earlier submission, and we strongly support their implementation. In particular, we reiterate the likely benefits of a pilot program in NSW based on the progress made by Winnunga Nimmityjah Aboriginal Health Service in delivering health services to Aboriginal inmates in the Alexander Maconochie Correctional Centre in the ACT.[2]

Failure to treat mental health

Attacking recidivism and reducing reoffending is a key NSW government target. Dr Smith referred to:

> "clear evidence that untreated or under-treated mental illness contributes to crime levels and that good mental health care in appropriate settings prior to, during, and post-contact with the criminal justice system reduces reoffending."[3]

He stated that:

> "the evidence suggests that investment in early, effective and safe treatment of mentally unwell people and appropriate settings means patients get the treatment they need and helps keep our community safe."[4]

Legal Aid NSW strongly supports these views, advanced on behalf of the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**). Improving mental health care in the community, together with mental health care in custody, will reduce imprisonment rates and the number of deaths in custody, including the number of Indigenous deaths.

Specifically, we comment below on several issues raised during the evidence of Drs Smith and McMullen:

---

[1] Select Committee transcript 3 December 2020, p.31.
[2] Select Committee transcript 26 October 2020 p.31-32, 35-37, particularly evidence of Julie Tongs.
[3] Select Committee transcript 3 December 2020 p.30.
[4] Select Committee transcript 3 December 2020 p.30.

Intake screening for mental health and use of safe cells

Death in custody inquests have repeatedly identified deficiencies in the mental health screening process of inmates on entry into custody, and the use of safe cells. Questioning of various witnesses by the Committee indicated an interest in these areas.[5]

Other issues commonly identified at recent inquests include:

- the failure to identify past self-harm and suicide attempts;
- the failure to obtain and review earlier medical records, both from within the custodial setting and from community health providers;
- the failure to obtain and provide psychiatric medications in a timely fashion;
- the failure to identify psychosis and the danger of an inmate to either themselves or others; and
- lengthy waitlists to access mental health nurses and psychiatry services.

Inquest findings that demonstrate these failures are accessible to Committee members, and we would encourage a review of these findings to better understand the breadth and depth of inadequacies in mental health treatment.[6] Our Coronial Inquest Unit solicitors have appeared as legal representatives in each of these inquests to advocate for improved health care and to support family members and others affected by failings in the custodial system.

A: Glenn Russell

Glenn Russell was a 32 year old who had spent over 12 years of his life in custody.[7]

Glenn entered custody in March 2015 with a recent history of self-harm, which included reports to police and community medical personnel. He had stitches to his forearms from a recent incident of self-harm, which were removed by Justice Health nurses after 10 days in custody. The significance of his immediate past history and self-harm attempts were not identified by Justice Health or Corrective Services during the intake screening process. On intake, Glenn identified as having been medicated in the community for schizophrenia and depression. There was a significant delay in contacting his community GP, and he was not provided with his psychiatric medication until 3 ½ weeks after entering custody.

After entering custody, his initial Justice Health screening assessment resulted in a Patient Administration System (**PAS**) rating of 5, meaning that he required follow-up but within no specified time frame. The Coroner found this was incorrect and entirely inappropriate.[8] The evidence demonstrated he should have been PAS 2, requiring mental health assessment within 3 - 14 days.

Glenn Russell committed suicide in his cell 7 weeks after entering custody, having never been psychiatrically assessed by either a mental health nurse or psychiatrist whilst in custody, despite his recent self-harm and past diagnosis of schizophrenia and depression.

---

[5] Select Committee transcript 3 December 2020 p.37-38 Dr Smith; 8 December 2020 p.24-28 Ms Hoey, Justice Health.
[6] https://www.coroners.nsw.gov.au/coroners-court/coronial-findings-search.html
[7] Inquest into the Death of Glen Russell, Deputy State Coroner Stone, Findings 26 June 2018.
[8] Glenn Russell Findings, para 1-2-113.

B: Jonathon Hogan

Jonathan Hogan was a 23 year old Aboriginal man from Canberra.[9] He was identified as having complex mental health needs when entering custody at Junee Correctional Centre in August 2017. However, in the following 6 months, there was an abject failure to provide adequate and timely mental health treatment. Jonathan had a history of depression, schizophrenia and suicide attempts. He was psychotic on entry into custody. Despite repeated orders by Local Court magistrates under s.33 of the Mental Health (Forensic Provisions) Act to have him psychiatrically assessed and sent to a mental health facility, this never occurred because Corrective Services said he was a sentenced inmate.

A court-ordered Justice Health mental health assessment in September 2017 found that Mr Hogan was acutely psychotic. Despite this finding, and the need for intensive treatment, he was returned to Junee Correctional Centre and never received any targeted treatment. The psychiatric report was never considered by clinicians at Junee, and he was not reviewed at all by a mental health nurse or psychiatrist over a period of almost 3 months leading up to his death. Jono committed suicide in early February 2018 whilst alone in his cell at Junee. The Coroner found a clear need for Aboriginal mental health workers at Junee Correctional Centre and made a recommendation to that effect.

C: David Dungay

David Dungay's death raises significant issues beyond the scope of this response. However, in relation to custodial healthcare, evidence at the inquest into David's death in December 2015 demonstrated that failures in primary health care contributed to a decline in Mr Dungay's mental health. Mr Dungay had been a diabetic since he was a young child. During the course of his lengthy incarceration, since 2008, he attended several specialist appointments at the Diabetes Clinic at Prince of Wales Hospital whilst incarcerated at Long Bay gaol.[10]

Despite repeated requests by the Diabetes Clinic for increased monitoring and follow-up, the evidence demonstrated that Justice Health did not facilitate Mr Dungay's attendance at follow-up appointments, nor provide the information on Mr Dungay's health status that was requested. With time, his diabetes became more unstable and this likely played a role in events on the day of his death.[11]

D: DJ and RP

DJ was killed in his cell at MRRC in 2012 by his cellmate BB. Over two years earlier, RP had also been killed in his cell at MRRC, by a different prisoner. Their inquests were heard together in 2018-19.[12] Each man had died after being placed with an inmate who had an active schizophrenic illness. At inquest, the Coroner heard evidence of significant resource constraints in relation to mental health beds and access to treatment, both at MRRC and within the custodial system generally.

---

[9] Inquest into the Death of Jonathon Hogan, Deputy State Coroner Grahame, Findings 6 May 2020.
[10] Inquest into the Death of David Dungay, Deputy State Coroner Lee, Findings 22 November 2019.
[11] The Coroner did not make findings on this aspect of David Dungay's care and treatment, despite receiving evidence and submissions on this issue.
[12] Inquest into the deaths of RP and DJ, Deputy State Coroner Grahame, Findings 4 July 2019.

> In DJ's case, it was clear that the psychiatrist assessing BB felt pressure to remove him from a safe cell and put him into a normal cell placement, in order to not block the system. If prison health facilities were adequately resourced, he would have sent BB to the mental health screening unit at MRRC, or kept him in a safe cell. The dangerousness of BB's delusions was well-known to that psychiatrist, however the evidence demonstrated severe bed shortages and lengthy waiting lists.[13] He said the situation in 2019 was much worse than in 2012.

On behalf of Justice Health, appropriate concessions were made to the Committee by Ms Wendy Hoey, particularly concerning blockages due to bed availability, and the release of prisoners back into the general prison population despite them having very serious, untreated mental health issues.[14]

Legal Aid NSW supports the solutions offered by Justice Health, including:

- Improved diversion of mentally ill offenders from the courts to local mental health services.[15]
- Increased medium-secure and low-secure mental health beds in custody.
- Improved treatment in custody, including by establishing subacute areas that provide treatment and programs for mental illness.
- Moving patients from the custodial setting into secure settings, including local health districts, to access mental health treatment in hospitals.[16]

Legal Aid NSW would support recommendations by the Committee in relation to these specific proposals.

Involuntary treatment in custody

Legal Aid NSW strongly supports the position of the RANZCP, as put forward by Dr Smith, to the effect that involuntary or "enforced care" should be provided in a hospital and not in the prison system, as occurs currently through the use of Long Bay Hospital.[17] Confusion sometimes exists between the Forensic Hospital at Malabar and Long Bay Hospital. To be clear, Long Bay Hospital is a facility that has been gazetted as a mental health facility under the Mental Health Act 2007. It is within the Long Bay complex run by Corrective Services NSW, and the security and operation of the facility is governed by Corrective Services. Prison officers guard mental health patients within that facility, specifically at E, F and G Wards, which together have the capacity to house 40 patients. Nurses and doctors employed by Justice Health provide mental health services.

David Dungay was a correctional patient at Long Bay Hospital at the time he was restrained by prison guards and died in December 2015. He was housed in cell within G Ward, where he was receiving involuntary mental health treatment. Force could be used to medicate him.

---

[13] The assessing psychiatrist's evidence was that there were about 50 people on the MHSU waiting list, who are unmedicated and who are seriously mentally ill in regional gaols: see Inquest into the deaths of RP and DJ, 28 February 2019, transcript p.18.
[14] Select Committee transcript 8 December 2020 p.30.
[15] Noting Ms Hoey's evidence that diversion is only available at 22 of the 54 adult courts throughout NSW, which is presumably a reference to the use of Mental Health nurses at these courts: Select Committee transcript 8 December 2020 p.30.
[16] Select Committee transcript 8 December 2020 p.30.
[17] Select Committee transcript 3 December 2020 p.32-34.

He spent about 22 hours per day in his cell. His main interactions were with prison officers and Justice Health nurses and doctors. If Mr Dungay had been held in a hospital within the community, as advocated by the RANZCP, then he would have been restrained by health professionals and/or security personnel, should that have been necessary for his treatment.[18] Instead, he was restrained by prison guards who were shown to have been completely untrained in the dangers of positional asphyxia.

Dr Smith emphasised that NSW is the only state in Australia that treats prisoners who require involuntary mental health treatment within the gaol system. All other jurisdictions provide involuntary mental health treatment to prisoners (who have effectively been scheduled) by sending them to mental health facilities outside of the correctional system. Concerns raised by members of the committee as to the management of violent mental health patients were countered by Dr Smith who indicated:

> "there is data to suggest that people in prison who are acutely unwell can be transferred to local health district hospitals with no increase in restrictive practices."[19]

Dr Smith referred to the practice in other states of transferring prisoners to secure community settings:

> "where they have long experience of dealing with people who are potentially violent or aggressive or high risk."[20]

The Forensic Hospital at Malabar, which is staffed by Department of Health employees and does not utilise prison guards, houses about 135 people with severe mental illnesses. Most of these people are forensic patients. A large proportion of them have killed others and subsequently been found "not guilty mental illness", thereby becoming forensic patients. The Forensic Hospital is equipped to deal with the most floridly psychotic and dangerous mental health patients, many of whom have a violent history. Similarly, secure community mental health facilities at Cumberland Hospital and other locations are also equipped to deal with patients who are psychotic and dangerous.

Corrective Services NSW and NSW Health currently operate under a Security Conditions Protocol which effectively mandates that the involuntary treatment of prisoners must occur at Long Bay hospital, despite the availability of community-based mental health facilities (both as a matter of practice, and as an option under the legislation).[21] The protocol provides that transfer of a patient requiring involuntary treatment to a facility other than within a correctional facility may only occur in exceptional circumstances.[22] There is no clinical basis for this requirement, and it is completely contrary to principles which require equivalence in health care. In contrast, when prisoners in NSW experience a physical illness requiring inpatient intervention, they are transferred to a community hospital for specialist intervention. It is unclear why a similar process is not occurring for those experiencing mental illness.

Our Mental Health Advocacy Service is aware of significant delays that prevent mentally ill inmates being transferred from other gaols to the Long Bay Hospital. These delays are due

---

[18] Security personnel in hospitals work under the direction of health care staff including nurses. Management of mental health patients is driven from a health perspective rather than a security and control perspective.
[19] Select Committee transcript 3 December 2020 p.33.
[20] Select Committee transcript 3 December 2020 p.33.
[21] See attachment: Security Conditions Protocol.
[22] See attachment: Security Conditions Protocol at 4.4.1 - 4.4.3.

to inadequate numbers of mental health beds. Mental Health Review Tribunal annual reports demonstrate prisoners wait one and two months or more to be admitted to Long Bay Hospital after initial psychiatric assessments determine they require involuntary treatment. During that waiting period they cannot be treated involuntarily.[23] No such delay occurs in the community, where a person found to be mentally ill or mentally disordered is transferred immediately to a mental health facility.

Once at Long Bay Hospital, mental health patients are detained in their cells, under prison guard, for around 22 hours per day. No formal psychotherapy, group programs or allied health services are offered. A recent scientific paper by eminent psychiatrists in relation to Australian and New Zealand prisons found:

> "the involuntary treatment of serious mental illness in custodial settings is likely to compromise clinical care, carries a significant risk of serious harms, encourages inappropriate management of prisoners and breaches human rights conventions."[24]

For these reasons, Legal Aid NSW strongly supports the treatment of all prisoners who require involuntary treatment within community mental health facilities, not Long Bay Hospital. We support a fundamental change of practice within NSW to align our State with best practice, and the practice in all other Australian states – namely by discontinuing the use of Long Bay Hospital for prisoners who are involuntary mental health patients.

This change in practice can be effected firstly by removing the gazettal of Long Bay Hospital as a mental health facility under the Mental Health Act, thereby removing it as an option for the treatment of correctional patients.[25] The existing legislation under the Mental Health (Forensic Provisions) Act 1990 allows correctional patients to be transferred to community mental health facilities. On a practical level, this change would require improved processes at community mental health facilities to accept mental health patients that are prisoners.[26] It may also require an increase in the number of community beds, including beds within secure facilities for those patients who are potentially violent or aggressive or high risk.

Secondly, Legal Aid NSW proposes a recommendation by the Committee that the Security Conditions Protocol be rescinded. Together these two actions would ensure that involuntary mental health treatment for prisoners in mental health facilities outside of the correctional system would become standard practice.

Independent oversight of Corrective Services by the Law Enforcement Conduct Commission

Legal Aid NSW acknowledges the evidence of LECC Commissioner Lea Drake, in relation to there being no independent oversight of Corrective Services as to misconduct that may have occurred in relation to a death in custody. It also strongly supports her criticism of the delays in the Coroners Court, and the impact this has not just on families of the deceased, but also

---

[23] Such as being required to take medication.
[24] Andrew Carroll et al, (2020): No involuntary treatment of mental illness in Australian and New Zealand prisons, The Journal of Forensic Psychiatry & Psychology at 10.
[25] See the process for involuntary treatment of prisoners under s.55 of the Mental Health (Forensic Provisions) Act.
[26] It would likely also require agreements between Local Health Districts and Corrective Services and Justice Health to facilitate the transfer and treatment of prisoners to community mental health facilities.

on others, such as police officers whose conduct is under scrutiny.[27] Better funding of the Coroners Court would alleviate some of these concerns.

The Committee has questioned whether LECC oversight of deaths in Corrective Services custody would improve accountability and transparency, having correctly identified that deaths in prison custody do not attract the same oversight as occurs when there is a death in NSW Police custody.

We do not consider there is a wholesale need to alter the system that investigates deaths in custody. Our primary submission is that the NSW Police would remain the key investigators of any death in prison custody, acting under the direction of the NSW Coroner. The difficulty of another body such as LECC being tasked with investigating deaths in custody is demonstrated by the fact that even now, LECC staff do not attend regional Critical Incidents.[28] When they do attend, LECC staff listen to investigations by NSW Police, observe what is happening, but do not investigate themselves. The complexity of police investigations and the expertise required of critical incident investigators were emphasised by Assistant Commissioner Crandell.[29]

In the experience of our solicitors, two of the major issues which result in pain and disappointment for First Nations families of a deceased are:

- the delays in the Coroners Court and lack of information to families (which are largely due to inadequate resourcing);[30] and
- the need for the system as a whole (NSW Police, Forensic Medicine, the Coroners Court and other service providers) to become more culturally competent, through employment of Aboriginal staff, cultural training, and special protocols which are culturally specific and will improve experiences for First Nations families.[31]

There is inherent suspicion on the part of Aboriginal families when a family member dies in prison custody. Greater scrutiny as to whether any misconduct has occurred may help to address these concerns and may play a preventative role that deters such misconduct. As a general proposition, Legal Aid NSW would support increased and more timely scrutiny in relation to potential misconduct surrounding a death in prison custody.

However, the exact mechanism for how this could be achieved is more difficult to determine. For example, whilst LECC has expertise in complaint handling and assessing misconduct, it does not have expertise in relation to Corrective Services and custodial settings. Its expertise concerns law enforcement. Conversely, the Inspector of Custodial Services has significant expertise in Corrective Services and custodial settings, including the important matter of custodial health care, but does not have any judicial expertise or a complaint handling function.[32] Further consultation may be appropriate if an oversight mechanism in addition to the NSW Coroner is to be implemented for deaths in prison custody.

---

[27] Select Committee transcript 7 December 2020 p.37-38.
[28] Select Committee transcript 8 December 2020 p.42-43.
[29] Select Committee transcript 7 December 2020 p.30, with most Critical Incident investigations being lead by a Detective Inspector, with an average of 20 years experience.
[30] Legal Aid NSW submission p.75-78.
[31] Legal Aid NSW submission p.80-81.
[32] Select Committee transcript 8 December 2020 p.44, noting that in the ACT, the ACT Inspector of Custodial Services does have an investigative function concerning deaths in custody

Promoting cultural competence

Despite the relatively large number of Aboriginal or Torres Strait Islander staff with NSW Police,[33] in the experience of our solicitors, there remain high levels of dissatisfaction and a lack of trust within the Aboriginal community as to investigations undertaken by NSW Police. We support Assistant Commissioner Crandell's evidence that developing a NSW Police protocol in relation to dealing with families would be helpful,[34] in order to address issues around levels of communication and the provision of information, particularly in relation to Aboriginal families. We also repeat our earlier support for "the training of investigating police to communicate appropriately with Aboriginal families and to better understand Aboriginal culture, including cultural beliefs regarding post-mortem procedures, and kinship structures," particularly for those police investigating an Aboriginal death in custody or within a police operation.[35]

In terms of promoting cultural competence at the Coroners Court, we support the remarks of Mr Shoebridge in relation to the need for a public engagement process concerning the development of the proposed Coroners Court practice note regarding Aboriginal and Torres Strait Islander deaths in custody.[36] The process of consulting First Nations organisations and community members together with other stakeholders in a public forum to address existing deficiencies in the coronial system would promote confidence in outcomes, and would allow those organisations and community members to voice their concerns and develop their own solutions. A recommendation to this effect by the Committee would be welcomed.

Systematic review of coronial findings and recommendations

In our earlier submission, we indicated that in relation to deaths in custody, "none of the inquest findings and recommendations are the subject of further systematic review or analysis by any NSW agency or body, in particular with a view to preventing or reducing the likelihood of further deaths in custody."[37]

We supported the establishment of a Coroners Prevention Unit similar to Victoria, to assist coroners in the development of prevention-focused coronial recommendations. We also supported the establishment of a specialist death review team with a statutory basis, similar to the Domestic Violence Death Review Team, to monitor and inform policy and systemic change for all deaths in custody, particular Aboriginal and Torres Strait Islander deaths.[38]

---

[33] Select Committee transcript 7 December 2020 p.17-18, Assistant Commissioner Crandell indicating NSW Police has 3.1 per cent or 658 Aboriginal or Torres Strait identified employees, including 470 police officers and 55 Aboriginal community liaison officers.
[34] Select Committee transcript 7 December 2020 p.21.
[35] Legal Aid NSW submission p.84-85.
[36] Select Committee transcript 7 December 2020 p.54.
[37] Legal Aid NSW submission p.87.
[38] Legal Aid NSW submission p.88.

A further possibility is that the Inspector of Custodial Services be given a specific function to monitor coronial findings and recommendations, and report on those publicly in its annual report.[39] Legal Aid would NSW would support that taking place in the event that our earlier suggestions for a Coroners Prevention Unit and/or a death in custody review team were not implemented. This would require a significant investment of resources, given the Inspector's current lack of resources to effectively fulfil its mandate.

We thank you for the opportunity to provide further comment on the evidence received by the Select Committee and look forward to the Committee's report and recommendations.

Yours sincerely

Brendan Thomas
Chief Executive Officer
Legal Aid NSW

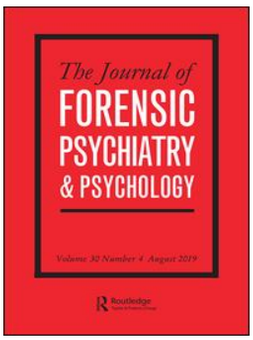
Attachments:

Andrew Carroll et al, (2020): *No involuntary treatment of mental illness in Australian and New Zealand prisons*, The Journal of Forensic Psychiatry & Psychology at 10.

Royal Australian and New Zealand College of Psychiatrists, Position Statement no.93: *Involuntary mental health treatment in custody*, November 2017.

Security Conditions Protocol (section 76D of the Mental Health (Forensic Provisions) Act 1990) between Director-General, NSW Department of Health and Commissioner of Corrective Services in relation to Forensic Patients and Correctional Patients.

[39] Select Committee transcript 8 December 2020 p.44.



The Journal of Forensic Psychiatry & Psychology

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rjfp20

No involuntary treatment of mental illness in Australian and New Zealand prisons

Andrew Carroll , Andrew Ellis , Andrew Aboud , Russ Scott & Krishna Pillai

To cite this article: Andrew Carroll , Andrew Ellis , Andrew Aboud , Russ Scott & Krishna Pillai (2020): No involuntary treatment of mental illness in Australian and New Zealand prisons, The Journal of Forensic Psychiatry & Psychology

To link to this article: https://doi.org/10.1080/14789949.2020.1817524

Published online: 06 Sep 2020.

THE JOURNAL OF FORENSIC PSYCHIATRY & PSYCHOLOGY
https://doi.org/10.1080/14789949.2020.1817524

No involuntary treatment of mental illness in Australian and New Zealand prisons

Andrew Carroll[a], Andrew Ellis[b], Andrew Aboud[c], Russ Scott[c] and Krishna Pillai[d]

[a]Centre for Forensic Behavioural Science, Swinburne University of Technology, Alphington, Australia; [b]School of Psychiatry, Faculty of Medicine, University of New South Wales, Sydney, Australia; [c]Prison Mental Health Service, Queensland Health, Brisbane, Australia; [d]Auckland Regional Forensic Psychiatry Services, New Zealand

ABSTRACT

Reflecting worldwide trends, as the prison population in Australia and New Zealand has risen over the past decade, the number of inpatient beds available for the involuntary treatment of mentally ill prisoners transferred from correctional custody has not increased commensurately. In this context, there have been calls to allow involuntary treatment of serious mental illness in prisons. This narrative review considers the extent of unmet psychiatric need within prisons in Australia and New Zealand and considers whether there is any evidence base for involuntary treatment of serious mental illness in prisons. The review concludes that the involuntary treatment of serious mental illness in custodial settings is likely to compromise clinical care, carries a significant risk of serious harms, encourages inappropriate management of prisoners and breaches human rights conventions. The authors found no evidence of improved clinical outcomes or any other benefits directly or indirectly linked to involuntary treatment of serious mental illness in correctional settings. Finally, the review describes the Prison Mental Health Service in the Australian jurisdiction of Queensland and suggests that this represents a 'best practice' model for the management of mentally ill prisoners.

ARTICLE HISTORY Received 29 February 2020; Accepted 25 August 2020

KEYWORDS Involuntary treatment; mental illness; prisons; improve; quality; outcomes; restrictive; restraint; seclusion

Introduction

In the month before the release of the findings of a Coronial Inquest into the death of a mentally ill prisoner in a 'prison hospital' in Sydney, New South Wales, an article entitled 'Involuntary psychiatric treatment in custody – To be unequivocally opposed or supported with safeguards and significant service improvements?' appeared in *Australian and New Zealand Journal of Psychiatry* (Spencer & Dean, 2019). In the two page article, two senior Australian forensic

CONTACT Russ Scott russ.scott@health.qld.gov.au

psychiatrists from New South Wales argued that 'significant numbers' of prisoners with serious mental illness could be treated involuntarily in custody 'with appropriate legislative safeguards' and cited for support an obscure 'survey' which appeared on a website in the United States five years earlier (Torrey et al., 2014).

To investigate whether any research has considered any outcomes related to involuntary treatment of serious mental illness in prisons, the authors conducted a review of the literature by searching PubMed, PsychINFO, Google Scholar, grey literature and websites for relevant articles using the terms 'involuntary treatment', 'mental illness', 'prisons', 'correctional centres', 'improve', 'quality' 'outcomes' and related synonyms from 2010 onwards.

The increasing prison population in Australia and New Zealand

The adult prison population in Australia and New Zealand continues to rise disproportionately to the general population. As of the end of March 2020, the average daily number of persons in prison in Australia was 44,159, an increase of over 30% from the previous five years (Australian Bureau of Statistics, 2020). From 2017 to 2020, the population of Australia increased by 1% to 25.5 million (Australian Bureau of Statistics, 2020). Over the same period, prison numbers in Australia increased by 4% and the national daily imprisonment rate increased from 216 to 223 prisoners per 100,000 adult population (Australian Bureau of Statistics, 2020).

Aboriginal and Torres Strait Islander (ATSI) people are overrepresented in the prison population compared with the general population (Heffernan et al., 2012) Although ATSI adults are estimated to make up only 2% of the total population of Australia (Australian Bureau of Statistics, 2020), they constitute 27% of the prison population. The total ATSI imprisonment rate was 2,582 prisoners per 100,000 adult ATSI population (Australian Bureau of Statistics, 2020), more than 10 times the rate of the non-ATSI population.

Between 2015 and 2019, whilst the population of New Zealand increased by 8% to 4.95 million (New Zealand Government Statistics, 2019), there was a 17% increase in the New Zealand adult prison population (Department of Corrections New Zealand, 2019). In March 2019, the national adult male daily imprisonment rate in New Zealand was 210 per 100,00 adult population (Department of Corrections New Zealand, 2019). Māori and Pacific peoples are grossly overrepresented in the prison population compared with the general population. Although Māori and Pacific peoples make up 17 and 9%, respectively, of the total population of New Zealand, they constitute 51% and 12% of the national prison population (Department of Corrections New Zealand, 2019).

The burden of mental illness in prisoners

As a population cohort, persons detained in prisons have a disproportionate burden of mental illness compared to population cohorts in the general community and are at increased risk of morbidity from self-harm and untreated mental illness and mortality from suicide and violence (Baranyi et al., 2019).

An Australian study found the overall prevalence of any mental disorder in prisoners was 43% and the prevalence of any substance use disorder was 55% whilst the prevalence of a co-occurring mental illness and substance use disorder in the past 12 months was 29% (T. Butler et al., 2011). Prevalence rates are even higher for ATSI people (Ogloff et al., 2017) and prisoners with mental illness are more likely to have a co-morbid intellectual disability (Dias et al., 2013).

Prior to their imprisonment, those with a dual diagnosis report a significantly low level of contact with mental health, alcohol and substance treatment services (Hunt et al., 2015). A study in 2019, found that 40% of prison entrants and 37% of prison dischargees reported a previous diagnosis of a mental health disorder including alcohol and other substance use disorders (Australian Institute of Health and Welfare, 2019). A more recent study in an Australian adult prison found that nearly half of those surveyed reported lifetime suicidal ideation and 31% reported attempting suicide at some point in their lives (A. Butler et al., 2018).

A large study from New Zealand found that as well as markedly high prevalence rates for major mental disorders in the prison population compared with community samples, only 46% of depressed inmates and 37% of those with psychosis were receiving treatment (Brinded et al., 2001).

A more recent survey found that 91% of New Zealand prisoners had a lifetime diagnosis of a mental health or substance use disorder and were seven times more likely to have a lifetime prevalence of any substance use disorder compared to the general population (Indig et al., 2016). A study of 1212 adult males incarcerated across 13 New Zealand prisons, accounting for 14% of the national prison population, found that a third reported a lifetime history of suicidal ideation, of whom half attempted suicide at some point (Favril et al., 2020). Prisoners in New Zealand had high rates of co-morbid and complex presentations and 46% of those with current mental health needs had not accessed a mental health clinician in the past year. Māori prisoners had the highest prevalence of two or more mental health or addiction disorders and those with a psychotic illness generally do not receive optimal treatment (Rangihuna et al., 2018).

The unmet mental health needs of prisoners

Isolation, overcrowding, victimization and the poor physical environment of prisons are likely to contribute to a deterioration in the mental health of

prison entrants. The mental health burden of remand prisoners, who appear to account for a substantial proportion of the increase in the prison population in both Australia and New Zealand, is even more acute than those of sentenced prisoners (Foulds & Monastario, 2018). Vulnerable, mentally ill prisoners are often stigmatised in prison and may be intimidated by other prisoners to divert the sedating medication they have been dispensed for their mental illness (McKee et al., 2014).

Perversely, for many, imprisonment may offer an opportunity for their unmet mental health needs to be recognized and addressed (Tyler et al., 2019). But as a result of a number of factors, the identification and treatment of mental illness and substance use disorders in prisons in Australia and New Zealand is generally sub-optimal (Gonzales & Connell, 2014; Skipworth, 2019).

As well-limited funding and resources and the ethical issues relating to providing in-reach mental health care in an environment which prioritizes order, routine, regulation and control, the practical challenges unique to correctional settings – scarcity of confidential interview space, clinician and prisoner safety issues, compromise of confidentiality of records (Olley et al., 2009) and the lack of integration and shortcomings in ensuring continuity of care between prisons and on release (Georgiou & Townsend, 2019) – all contribute to the difficulty attracting clinicians to work in correctional centres (Stephenson & Bell, 2019; Wright et al., 2014).

Prisoners are likely to be at increased risk of morbidity from victimization and self-harm and mortality from suicide and violence (Igoumenou et al., 2019). Prisoners with a history of mental illness have especially poor health and social outcomes (Cutcher et al., 2014; Young et al., 2018) and steeper trajectories of psychological distress after release from prison (Thomas et al., 2016). Prisoners are also at markedly increased risk of death particularly from substance use (Chang et al., 2015) accidental overdoses (Forsyth. et al., 2018) or suicide following release into the community (Pratt et al., 2006). One study estimated that the number of deaths within a year of release from prison in Australia was nearly 10 times the annual number of deaths in custody (Kinner, et al., 2011).

Since prisoners released with serious, untreated mental illness are also at increased risk of re-offending and re-imprisonment compared with those without mental illness (Adily et al., 2020; Igoumenou et al., 2015), early detection and intervention to treat mental illness and substance use disorders in prison is imperative to improve outcomes (Forrester et al., 2018) including reducing prison returns (Evans et al., 2017). The closure of psychiatric beds in the community has been shown to be associated with an increase in transfers from prison to hospital for treatment (Keown et al., 2019). Whilst providing prisoners with health care is not considered politically popular, the lost opportunity to begin treatment of mental illness and substance use in

correctional custody is ultimately reflected in societal costs and risks to the safety of the wider community (Adily et al., 2020; MacDonald et al., 2010).

The neglect of community mental health services

In Australia, as has occurred in other countries, expenditure on mental health care continues to be neglected. In the last decade in Victoria, the second most populous state in Australia, funding to clinical mental health services did not grow proportionately with population growth. In 1994/4, Victoria had the highest per capita expenditure on mental health in Australia (Australian Institute of Health and Welfare (AIHW), 2017). By 2015/16, as a result of significant population growth without matching growth in funding for mental health, Victoria had the lowest per capita spend on mental health across Australia. In 2019, the Victorian Auditor-General reported that adult mental health services in Victoria provided poor community coverage with rising emergency department presentations and increasingly acute admissions to insufficient hospital beds which resulted in shorter inpatient length of stay and higher unplanned readmission rates (Victorian Auditor-General, 2019). Currently, investment in mental health care in Victoria is the lowest in the country. Expenditure in the general adult sector was 27% less than the national per capita average with the result that Victoria had the lowest rate of community service contacts and the smallest general adult psychiatric bed base in Australia (Allison et al., 2019).

It was in this context that a Royal Commission was established to examine the mental health system in Victoria. In its interim report of 2019, the Commission lamented 'For too long mental health has been relegated to the shadows within the broader health system. Historical underinvestment and increasing demand mean that services can no longer respond adequately to people living with mental illness, their families and carers'. (Royal Commission into Victoria's Mental Health System, 2019).

Several stakeholders have advocated that the Royal Commission should consider making a recommendation that the *Mental Health Act 2014* (Vic) be amended to enable involuntary treatment of mental illness in Victorian prisons. In a submission to the Royal Commission, a board member of the Victorian Institute of Forensic Mental Health and a member of the Mental Health Review Tribunal of Victoria referred to the plight of mentally ill prisoners: 'It is not acceptable in this day and age to have people with severe mental illness detained in the most brutal of environments (where they are deluded, distressed and confused because they will not accept treatment) and be unable to compulsorily treat them within prisons or admit them to a health service where they can be treated because there are no available beds' (Vine, 2019).

In response, the Royal Australian and New Zealand College of Psychiatrists Faculty of Forensic Psychiatry, Victorian Branch Working Group produced a detailed discussion paper expressing concern at any suggestion of legislating for involuntary treatment of mental illness inside prisons (Royal Australian and New Zealand College of Psychiatrists, Faculty of Forensic Psychiatry, Victorian Branch Working Group, 2020) – a position consistent with the formal position of the Royal Australian and New Zealand College of Psychiatrists (Royal Australian and New Zealand College of Psychiatrists, 2017).

The failure to transfer a mentally unwell prisoner to an inpatient unit

The failure to appropriately treat or transfer a seriously mentally unwell prisoner from prison to an inpatient unit can have tragic consequences. In October 2001, during an admission to Cumberland Psychiatric Hospital in New South Wales, 35-year-old Scott Simpson had been first diagnosed with schizophrenia and commenced on oral anti-psychotic medication. In May 2002, Simpson was experiencing an exacerbation of his paranoid schizophrenia when he was placed in protective custody in the Metropolitan Remand and Reception Centre in Sydney. Less than three hours later, Mr Simpson killed his cellmate. The day after the murder, Mr Simpson was placed in segregation (solitary confinement). Over the next two years, Mr Simpson never established any therapeutic alliance with a succession of seven different psychiatrists in prison and appeared only to accept oral antipsychotic medication intermittently. Except for two short periods, Mr Simpson remained in solitary confinement in various prisons in New South Wales until March 2004, when he was transferred to the Long Bay Hospital in preparation for his trial in Sydney. At trial, when Mr Simpson was found not guilty of murder, the Supreme Court held that not only had Mr Simpson been psychotic at the time he killed his cell mate, but he was also psychotic at the time of the alleged offence for which he had been originally remanded into custody. From March 2002, when he was first remanded, Mr Simpson was never considered for transfer to a hospital mental health unit for involuntary treatment and, even after his trial when he was found to have been of 'unsound of mind' at the time of the murder, he remained in segregation until June 2004 when he hanged himself in his cell. Post-mortem toxicology revealed that at the time of his suicide, Mr Simpson had no detectable antipsychotic medication in his circulation. Mr Simpson had a well-documented history of a serious mental illness and past suicide attempts, including one previous attempt in the very cell in which he died. All of the psychiatrists who gave evidence during the Inquest opined that prolonged periods in solitary confinement would most likely have exacerbated Mr Simpson's mental illness, particularly his paranoia or

persecutory delusions. In his findings, the Coroner held that Justice Health and the Department of Corrective Services failed to ensure that Mr Simpson received adequate and timely treatment for his mental illness. In his recommendations, the Coroner emphasized that the *Principles for the Protection of Persons with Mental Illness* including that a person in correctional custody who is determined to have a serious mental illness has the right to the best available mental health care (State Coroner's Office and NSW Attorney General's Department, 2007).

Secure mental health beds in Australia

In Australia and New Zealand, a watch house is a collection of cells typically attached to or inside a police station, in which people who are suspected of a committing an offence are held under arrest until they can appear before a Magistrates Court, released on bail or transferred to the remand centre of a prison. In Australia and New Zealand, the term 'secure bed' refers to those inside a purpose-built forensic facility, which is secured by a high perimeter fence and security personnel and from which persons transferred from prison cannot easily abscond. Whilst the prison population in Australia and New Zealand continues to rise, the number of secure inpatient beds for the treatment of mentally ill offenders has not increased commensurately.

Australia is a federation of six states and two territories each of which has their own mental health services and legislation. The three eastern states of New South Wales, Victoria and Queensland make up nearly 80% of the total population of Australia. New South Wales, the most populous state, has a population of 8.1 million (Australian Bureau of Statistics, 2019). The Forensic Hospital in Malabar, Sydney which is operated by the Justice Health and Forensic Mental Health Network, was originally constructed with 135 beds. In 2008, only 30 'high secure' beds were opened. In 2020, only 127 beds are open. There are 24 beds in the medium secure Bunya Unit of Cumberland Hospital in Paramatta, 20 beds in the medium secure Castlereagh Unit of Bloomfield Hospital in Orange and 30 beds in the Kestrel Unit of Morrisset Hospital in Hunter New England making a total of 201 secure inpatient mental health beds in New South Wales.

In New South Wales, a mentally ill person charged with an offence who has been refused bail is likely to spend considerable time in custody, rather than in a mental health facility. Even after court proceedings have concluded, forensic patients in New South Wales frequently wait another two years to be admitted to a mental health facility. The Annual Report of the New South Wales Mental Health Review Tribunal noted that at 30 June 2019, there were 30 male forensic patients waiting in custody for a bed in the Forensic Hospital which was five more that in 2017 (New South Wales Mental Health Review Tribunal, 2019).

Victoria, the most centralized and smallest mainland state, is also the second most populous Australian state with a population of 6.7 million. In Victoria, the Thomas Embling Hospital in Fairfield, Melbourne operated by the Victorian Institute of Forensic Mental Health (Forensicare) opened in 2000 with 89 'high secure' beds. In 2003, eleven beds were added and in 2018, a further 12 beds were opened. In March 2019, the eight-bed Apsley Unit was opened to treat acutely unwell patients transferred from prison, bringing the total number of beds within the secure perimeter to 120. Outside of Thomas Embling Hospital, there are 16 beds in the low secure Jardine Unit. There are no medium secure beds in Victoria.

In Queensland, the second largest by area and second most decentralized Australian state has a population of 5.1 million. In Queensland, the High Security Inpatient Services at The Park – Centre for Mental Health, Treatment and Rehabilitation (The Park) in Wacol, Brisbane opened in 2003 with 56 beds. In 2007, a further five beds were opened and in 2012, a 9-bed High Dependency Unit was added bringing the total number of beds within the secure perimeter to 70. There are also medium security mental health rehabilitation units at The Park (34 beds) and attached to The Prince Charles Hospital (20 beds) Townsville Hospital (21 beds) and Caboolture Hospital (23 beds) making a total of 168 secure inpatient mental health beds in Queensland. There has been no increase in the number of secure mental health beds in Queensland since 2012.

The total bed numbers of secure mental health units in the three most populous states in Australia are very low compared to similar jurisdictions. In Scotland which has a population of 5.5 million, considerably less than Victoria, there are 467 secure forensic mental health beds (Scottish Government, 2019).

Secure mental health beds in New Zealand

In New Zealand, short-term forensic care (SFC) special patients can be transferred from prison to a forensic mental health service for involuntary treatment. There are no 'high secure' beds in New Zealand. In 2017, 254 SFC special patients were transferred to one of 157 medium secure inpatient beds spread across the district health boards of Waitemata, Waikato, Capital and Coast, Canterbury, Southern and Whanganui (New Zealand Ministry of Health, 2019).

The transfer of prisoners to mental health inpatient beds is complicated by legislative provisions in all Australian jurisdictions and New Zealand by which courts can order persons in watch houses or remand centres to be transferred to secure forensic facilities for assessments in relation to fitness to stand trial and insanity defenses or as sentencing dispositions in cases in which the prisoner has a mental illness. These transfers may be outside the control of

prison mental health services and prioritized over the needs of mentally ill sentenced prisoners. Alternatively, community mental health services may have to agree to accept a patient transferred from prison or issue a 'certificate of available service' as occurs in Queensland and Victoria, which results in very high demand for inpatient beds and often long delays before a transfer occurs.

Statutory frameworks for the treatment of the mentally ill in Queensland

Queensland is unique in Australia and amongst the few jurisdictions in the world in which persons held in a watch house, remanded or serving a sentence in a prison are routinely transferred from custody to an authorised mental health service for the involuntary treatment of mental illness. Chapter 3 in the Queensland *Mental Health Act 2016* (Qld) is entitled 'Persons in custody'.

In 2017–2018, there were 263 'classified patient' admissions from custody to the Psychiatric Intensive Care Units or High Dependency Units of community mental health units including 33 admissions of high risk or serious offenders to the High Security Inpatient Services at The Park (Queensland Health, 2018). In 2018–2019, the total number of 'classified patient' admissions dropped to 250 (Queensland Health, 2019).

The criteria for involuntary treatment of serious mental illness are similar in all Australian jurisdictions and New Zealand. In the state of Queensland, which has arguably the most progressive mental health legislation in the world, the criteria for involuntary treatment are contained in sections 11 and 13 of the *Mental Health Act 2016* (Qld). The treatment criteria are (a) the person has a mental illness (2) the person does not have capacity to consent to be treated for the metal illness (3) because of the person's illness, the absence of involuntary treatment, is likely to result in imminent serious harm to the person or others or the person will suffer serious mental or physical deterioration and there is no 'less restrictive' option of treatment. By section 11, an 'involuntary patient' is defined to include a person detained in an authorized mental health service or public sector health service facility.

The criteria for an 'authorised doctor' who can make a person subject to an involuntary treatment order are also similar in all Australian jurisdictions and New Zealand. In the state of Queensland, by section 338 of the *Mental Health Act 2016* (Qld), the administrator of an authorised mental health service may appoint a doctor as an 'authorised doctor' if the administrator is satisfied that the doctor has the necessary professional qualifications and competencies.

Statutory framework for the treatment of the mentally ill in New South Wales

In New South Wales, the criteria for involuntary treatment are contained in sections 14 of the *Mental Health Act 2007* (NSW). By section 14 (1), a person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary (a) for the person's own protection from serious harm, or (b) for the protection of others from serious harm. By section 14 (2), in considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

New South Wales is the only Australian jurisdiction, and one of very few in the world, which also has legislation which authorises involuntary treatment inside a prison. By section 52 (1) of the *Mental Health (Forensic Provisions) Act 1990* (NSW), following a 'special hearing' of the Mental Health Review Tribunal, a person detained in a correctional centre may be classified as an involuntary patient by section 38 (5) of the *Mental Health Act 2007* (NSW) and be made subject to a Forensic Community Treatment Order (FCTO) and receive involuntary treatment for his or her mental illness in a prison.

In its most recent report, the New South Wales Mental Health Review Tribunal noted that the number of applications for a FCTOs tripled from 59 in 2015–2016 to 182 in 2018–2019 (New South Wales Mental Health Review Tribunal, 2019). The Mental Health Review Tribunal is required to conduct three monthly reviews of each person subject to a FCTO who is detained in a correctional centre. The number of these reviews doubled from 59 in 2016/17 to 125 in 2017/18

In New South Wales, the *Mental Health (Forensic Provisions) Act 1990* (NSW) section 55 (Transfer from correctional centre by Secretary) provides for the transfer of mentally ill prisoners from correctional centres to hospital mental health units. But in practice, adult male remand or sentenced prisoners are almost never transferred to hospital units for involuntary treatment of mental illness. Only female and juvenile prisoners are infrequently transferred to the Forensic Hospital at Malabar for this purpose. Within Long Bay Correctional Centre, the Long Bay Hospital has a 40 cell unit has been gazetted a 'mental health facility' under the *Mental Health (Forensic Provisions) Act 1990* (NSW) where male prisoners with mental illness can be involuntary medicated. The Long Bay Hospital 'mental health facility' provides little more than biological treatment. No formal psychotherapy, group programs or any allied health services are offered and prisoners in the 'mental health facility' are locked in their cells most of the day and do not have access to exercise yards and other recreation activities available to mainstream unit prisoners.

Statutory framework for the treatment of the mentally ill in Victoria

In Victoria, the *Mental Health Act 2014* (Vic) section 270 (Secure Treatment Orders) provides for the transfer of mentally ill prisoners from correctional centres to general hospital mental health units. However, in practice, this occurs only very occasionally usually to enable an aged offender to be transferred to a psychogeriatric ward. All mentally ill prisoners requiring involuntary treatment in Victoria are transferred to Thomas Embling Hospital.

In 2019, the average wait time for a male patient to be admitted to Thomas Embling Hospital for involuntary treatment was 40 days (Victorian Institute of Forensic Mental Health (Forensicare), 2019). In 2019, 80% of patients in Thomas Embling Hospital were 'Forensic Patients' detained pursuant to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) having been found not guilty on the grounds of mental impairment or unfit to stand trial. On average, a 'Forensic Patient' waits 319 days to be admitted to Thomas Embling Hospital following a recommendation for a Custodial Supervision Order (Victorian Institute of Forensic Mental Health (Forensicare), 2019).

Statutory framework for the treatment of the mentally ill in New Zealand

In New Zealand, the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) section 45 (Application for assessment may be made in respect of persons detained in prisons) provides for the transfer of mentally ill prisoners from correctional centres to hospital mental health units. In 2001, prison transfers of mentally disordered offenders were 2.31% of the overall prison population. By 2008, transfers fell to 1.04% and by 2015, the transfers were down to 0.67% (New Zealand Ministry of Health, 2016).

The right of mentally ill prisoners to access mental health care

In October 2007, the World Health Organization in Trencín, Slovakia promulgated the *Statement on Prisons and Mental Health* which emphasized the rights of prisoners to have appropriate mental health care.

> "Without urgent and comprehensive action, prisons will move closer to becoming twenty-first century asylums for the mentally ill, full of those who most require treatment and care but who are held in unsuitable places with limited help and treatment available. The mental health of prisoners cannot be left as an issue only for prison authorities.
>
> ... 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. Such prisoners

> should be diverted whenever possible to appropriate mental health services before reaching the prison gate. Those already in prison should be transferred to specialist psychiatric care as soon as possible" (World Health Organization, 2007).

On 17 December 2015, the United Nations General Assembly adopted the *Standard Minimum Rules for the Treatment of Prisoners* (the 'Nelson Mandela Rules') which stipulated that prisoners should enjoy the same standards of health care that are available in the community and that prisoners who require specialized treatment should be transferred to specialized institutions or to civil hospitals (United Nations, 2015).

On 11 February 2017, on the twenty-seventh anniversary of the release of Nelson Mandela from Verster Prison in South Africa, the World Psychiatric Association issued the Prison Public Health Position Statement which also emphasised the unmet need of the mental ill in prisons world-wide (Forrester et al., 2017).

Mentally ill prisoners and the principle of equivalence

Mentally ill offenders are already amongst the most marginalized and stigmatized persons in the community (Farabee et al., 2019). However, a recent quantitative cross-sectional retrospective study of 26 males admitted involuntarily from prison to two Melbourne acute inpatient units compared to 784 admitted from the community showed that those admitted from prison were no more likely to be subject to restrictive practices during their inpatient treatment and their psychotic illnesses could be safely managed outside of prison (Quinn et al., 2019).

The disinclination of inpatient mental health services to accept transfers of prisoners to inpatient services and the reluctance of community mental health services to assertively manage persons with serious mental illness who have been released from prison is short-sighted and discriminatory (Simpson & Jones, 2018).

By the 'principle of equivalence,' it is accepted that persons held in prisons have the right to a standard of health care at least equivalent to that available outside of prisons (Lines, 2006; Niveau, 2007). But serious mental illness is greatly over-represented in prison populations (Coid & Ullrich, 2011) and there are high rates of re-imprisonment (Thomas et al., 2015). Since the association between untreated mental illness and serious violence has also been well established (Short et al., 2013), there is a growing consensus that, rather than applying the 'principle of equivalence,' prisoners should actually receive higher standards of mental health care (Till et al., 2014) and that best practice should entail mental health services in prisons being resourced to effectively identify and manage both mental illness and substance use

disorders (McKenna et al., 2017). In cases in which these optimal conditions cannot be achieved or the person lacks capacity to accept treatment for their mental illness, then the person should be diverted out of a prison unit for assertive treatment in an authorized mental health facility.

In August 2014, the Inspector of Custodial Services, New South Wales Department of Justice promulgated 'Inspection standards for adult custodial services in New South Wales' (New South Wales Inspector of Custodial Services, Department of Justice, 2014). The document emphasized that mental illness in prison populations can be expected to be complex and the prevalence rates for all psychiatric morbidities are markedly higher than rates in community samples. The document emphasized that inmates typically come from disadvantaged social groups with a significant proportion having histories of alcohol or substance abuse and accumulated adverse life experiences. Further, the impact of imprisonment was likely to be stressful and potentially harmful from isolation from family and social networks, loss of privacy, loss of personal control and identity, austere surroundings, and overt or covert aggression and bullying by other inmates. In addition, for many inmates, there may be a lack of purposeful activity, heightened levels of uncertainty (particularly for remand inmates) and concerns about the outside world. The chapter entitled 'Mental health care' stipulated the following:

> "An assessment of mental health should be made as part of the initial health screening required for all inmates upon entry into custody, or if a more in-depth assessment is to be made, this should occur within the first 30 days of custody. Inmates who are suffering from a severe psychiatric illness should be assessed and transferred without delay so they may be managed by an appropriate tertiary or specialist health care facility, rather than a correctional centre. Prison diversion strategies to facilitate inmates' care from correctional settings to the community services, as appropriate, should be in place."

The elimination of seclusion and restraint in the treatment of mental illness

It is generally accepted that restraint and seclusion are experienced by most mentally ill persons as emotionally disempowering (Akther et al., 2019; Chambers et al., 2018) and that coercive practices, particularly physical restraint, are usually counter-therapeutic, at least in the short-term, and can re-traumatise patients (Sweeney et al., 2018). Mentally ill persons who recover and develop improved insight into their mental illness and their need for medication or seclusion may later accept that being secluded or forced to have parenteral medication was in their 'best interests.' However, it can be assumed that at the time they rejected the advice of a psychiatrist to accept the medication, and were secluded or forced to have medication, many patients would have felt disempowered.

In March 2007, the United Nations *Convention on the Rights of Persons with Disabilities* challenged member nations to improve access to voluntary mental health care and reduce coercive practices (United Nations, 2007). In 2014, the United Kingdom Department of Health called on inpatient mental health services to radically reduce the use of all restrictive practices and take action to end the use of restraint (United Kingdom Department of Health, 2014). In December 2018, an independent review of the U.K. *Mental Health Act 1983* concluded that further reforms were needed to reduce coercion in mental health care (United Kingdom Department for Health and Social Care, 2018). In 2019, the Commissioner for Human Rights of the Council of Europe called for the same reforms in European member nations (Sugiura et al., 2020).

In 2008, Te Pou Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development, set out a framework for 'best practice' in the reduction and elimination of seclusion and restraint in New Zealand (O'Hagan et al., 2008).

From 2010, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) has committed to reducing, and where possible, eliminating the use of seclusion and restraint in inpatient treatment (Royal Australian and New Zealand College of Psychiatrists, 2016). In December 2016, the Australian Health Ministers' Advisory Council endorsed the 'National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services' (Australian Health Ministers' Advisory Council, 2016).

Risks of coercive treatment of the mentally ill in prison

Trauma histories, including both traumatic and abusive experiences, are common amongst prisoners (Durcan, 2008) and prisons are not designed or operated to provide a 'therapeutic environment' for these disadvantaged persons. Since the functions of imprisonment include punishment and the protection of society, the containment of persons in correctional custody is inherently coercive and frequently requires the application or the threat of the application of force (Coyle, 2005). Since prison violence (inmate on inmate) is also common (Dye, 2010) and the adverse effects of trauma are cumulative and have the potential to aggravate symptoms of mental illness, exacerbation of mental illness in prison may relate to both importation and deprivation perspectives (Armour, 2012).

Developing a therapeutic alliance with a mentally unwell prisoner may be very challenging (Jacobs & Giordano, 2018). Involuntary treatment of mentally prisoners may contribute to blurring the important distinction between the roles of those non-health personnel employed by corrective services and those clinicians who visit prisons to offer treatment for mental illness. This blurring of the distinction between the two quite disparate roles jeopardizes the potential for mental health clinicians to develop a therapeutic alliance

with a mentally ill prisoner (Jordan, 2012). If correctional officers are required to bring a reluctant or paranoid prisoner to the prison medical centre and facilitate the enforced treatment of the prisoner by physical restraint or accommodating the prisoner in a segregation cell or detention unit, those prisoners may conclude that their treatment has more to do with 'maintaining the good order and safety' of the prison than addressing their treatment needs.

In November 2017, the RANZCP promulgated a strongly worded position paper which emphasized that involuntary treatment of mental illness in custodial settings compromised clinical care, encouraged inappropriate management of prisoners, and breached human rights.

> "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" (Royal Australian and New Zealand College of Psychiatrists, 2017).

Restrictive practices in prisons

Restrictive practices routinely adopted in prisons include requiring prisoners who self-harm or threaten to suicide be dressed in smocks and held in solitary confinement. Prisoners may have prolonged detention in segregation regimes of 23 hours per day lockdown with minimal opportunity for meaningful activity or exercise. Prisoners may be physically restrained by handcuffs, body belts, full body harnesses and spit hoods and recalcitrant prisoners may be extracted from cells by correctional officers using riot shields, capsicum spray, tear gas, batons or dogs. Prisoners may routinely have little or no access to family, carers and other supports during their incarceration and disciplinary segregation or solitary confinement may be used as a form of sanction simply for rule infractions (Cochran et al., 2017). Prolonged periods in solitary confinement or isolation in prison without the support of nursing and allied mental interventions were also likely to exacerbate severe mental illness (Haney, 2018) and increase the risk of deliberate self-harming (Kaba, et al., 2014) and suicide (Grassi et al., 2018).

The RANZCP Forensic Working Group discussion paper emphasized the risks associated with administrating sedating or tranquillizing medication to

unwell and usually un-co-operative persons outside properly staffed and equipped mental health services. In mental health inpatient services, rigid protocols exist for the use of psychotropic medications and medical and nursing staff are trained in the use of these medications including monitoring for serious, potentially life-threatening side effects. In mental health inpatient services, resuscitation equipment is also readily available and staff are required to maintain their proficiency in the use of this equipment.

Any involuntary treatment or application of restrictive practice in a mental health service requires that the treatment be authorized pursuant to specific provisions of the extant mental health act and the proper documentation of relevant decisions which can be subject to formal review and oversight by an independent mental health review tribunal.

Inappropriate involuntary treatment for behavioural management in prisons

In correctional centres in which involuntary treatment is permitted, there is the very real risk that sedation and tranquillisation may be inappropriately applied for the behavioural management of 'challenging' or 'disruptive' prisoners as occurred in the case of David Dungay, a 26-year-old indigenous man with paranoid schizophrenia who died in the Long Bay Correctional Centre in Sydney in December 2015. Mr Dungay had a history of convictions for violent offences and, since January 2008, was serving a long sentence. In June 2013, Mr Dungay was alleged to have seriously assaulted a correctional officer. In November 2015, after he had been non-compliant with the oral anti-psychotic risperidone, Mr Dungay was transferred to the Long Bay Correctional Centre 'mental health facility' and commenced on fortnightly depot zuclopenthixol.

Since his adolescence, Mr Dungay had diabetes for which he required daily subcutaneous insulin. On the day his death, Mr Dungay became 'aggressive and abusive' and refused to surrender a packet of biscuits he took with him into his cell. Although the nursing staff had concerns that eating the biscuits might elevate Mr Dungay's blood glucose, there was no suggestion that at the relevant time, Mr Dungay had become symptomatic of hyperglycemia or ketoacidosis or that he had become acutely psychotic. Five correctional officers rushed into his cell and restrained him face down on his bed. As he struggled violently, clawing at the correctional officers whom he also attempted to spit on and bite, a nurse employed by Corrections New South Wales obtained a 'phone order' from a junior house doctor and administered an intramuscular injection of midazolam into Mr Dungay's buttock. As Mr Dungay became increasingly aggressive, the nurse obtained a further phone order for an injection of droperidol. Shortly after receiving the midazolam injection and before the droperidol was given, Mr Dungay became

unresponsive and stopped breathing and could not be resuscitated. The Inquest heard that the prison health staff did not assess Mr Dungay's airway, breathing or vital signs before or after administering the midazolam. Neither flumazenil (the selective $GABA_A$ antagonist and antidote to benzodiazepines) nor emergency resuscitation equipment were available before the midazolam was administered and neither of the two nurses present had ever been involved in a real-world cardiopulmonary resuscitation or had emergency medicine experience.

The New South Wales Coroner later concluded that although cardiac arrhythmia was the immediate cause of Mr Dungay's death, poorly controlled type I diabetes, hyperglycaemia, treatment with anti-psychotic medication (which had the propensity to prolong the QT interval), hypoxaemia caused by prone restraint and extreme stress may all have contributed to his cause of death (Coroner's Court of New South Wales, 2019).

It is not difficult to envisage a 'slippery slope' effect by which the use of sedation and tranquillisation becomes more frequent to maintain the 'good order and safety' in prisons (Joubert et al., 2014) particularly those prisons operated by large corporations in which staff to prisoner ratios are usually less than in prisons operated by state government correctional services.

Involuntary treatment of serious mental illness and outcomes in prison

In 2014, the Treatment Advocacy Centre, a non-profit organization which purports to promote laws and policies aimed at eliminating legal and other barriers to treatment of severe mental illness, surveyed the parlous state of the treatment of the mentally ill in United States prisons and without any substantiation or evidence base, tentatively suggested that involuntary treatment of serious mental illness in correctional custody may be one option to address the national malaise (Torrey et al., 2014). The proposal attracted a trenchant critique which highlighted the fundamental harm of 'legitimization' and 'institutionalization' of enforcing treatment in a setting whose primary purpose is security and/or punishment and not primacy of the prisoner/patient (Felthous, 2014). Subsequently, a naturalistic study of 133 mentally ill inmates in the New Jersey Department of Corrections found no statistically significant difference in inmates' mean number of prison inpatient days in the year before compared to the year during which involuntary treatment was available (Salem et al., 2015). The small New Jersey study measured only one outcome and had significant limitations and a subsequent commentary raised concerns about the generalizability of the results particularly in prisons operated on 'private, for-profit' bases which are commonplace in the United States (Levine & Gage, 2015). By 2017, in a paper entitled 'Emptying the 'New Asylums,' the Treatment Advocacy Centre

abandoned its earlier position and made a number of alternative recommendations including better bed management as well as opening more hospital and non-hospital beds for mentally ill offenders (Fuller et al., 2017).

To investigate whether any research has shown any outcomes related to involuntary treatment of serious mental illness in prisons, the authors searched PubMed, PsychINFO, Google Scholar, grey literature and websites for relevant articles using the terms 'involuntary treatment', 'mental illness', 'prisons', 'correctional centres', 'improve', 'quality' 'outcomes' and related synonyms from 2010 onwards. The authors found no research which demonstrated any outcomes let alone any benefits directly or indirectly associated with involuntary treatment of serious mental illness in correctional settings.

A 'best practice' model of service ?

A recent review in the *British Medical Bulletin* called for the introduction of comprehensive mental health models throughout prisons to provide a rights-based framework of services for this socially disadvantaged population (Forrester et al., 2018). Currently, the 'best practice' model appears to operate in the Australian jurisdiction of Queensland. The Queensland Prison Mental Health Service (PMHS) provides in-reach specialist prison mental health services to 13 of the 19 correctional centres in Queensland. The six facilities without dedicated prison mental health services are able to access specialist mental health services through linkage with prison mental health teams at other locations or via community mental health services. The Queensland PMHS also has indigenous mental health workers who support ATSI prisoners. As well as daily clinic sessions in the prisons, the Queensland PMHS has an on-call psychiatrist rostered after-hours and on week-ends. The Queensland PMHS provides psychological interventions including Illness education, insight therapy and motivational interviewing-based abstinence counselling and a specialized dual diagnosis referral service which also features an opioid replacement therapy service and a referral pathway to drug and alcohol services and residential rehabilitation services in the community. The Queensland PMHS has also introduced the Self-Management and Recovery Training, a group program delivered by PMHS facilitators to address problematic behaviour and promote self-directed behaviour changes.

In Queensland in 2018–2019, 250 prisoners were transferred from prison to community mental health units, the great majority of whom were either already subject to community treatment authorities or required to be made subject to treatment authorities to facilitate involuntary treatment of their mental illness. In Queensland, the statewide Director of Forensic Mental Health Services monitors the number of days from when a recommendation is first made for a prisoner to be transferred to an authorised mental health service. In cases in which the delay in transfer

becomes inordinate, the Queensland Director of Forensic Mental Health Services can escalate the request to the Office of the Chief Psychiatrist who is also strongly committed to the 'principle of equivalence.' The Queensland PMHS also facilitates discharge planning and continuity of care by liaising with community mental health services and coordinating assertive follow-up for prisoners who are subject to treatment authorities as well as 'at risk' prisoners. This follow-up may extend beyond the administration of long-acting depot anti-psychotic medication and may include a clinician from the Transitions Co-ordination Program (TC Program) assisting the prisoner find post-release accommodation, linking the prisoner with non-government support agencies or the National Disability Insurance Scheme and also addressing any child safety or domestic violence risk issues (Green et al., 2016). The Queensland PMHS TC Program offers support to the prisoner for up to two weeks after the prisoner's release from correctional custody.

The positive effect of early detection and assertive treatment of mental illness and substance use disorders in prison has been demonstrated (McKenna et al., 2018) and the innovations of psychologically informed prison environments (Bennett & Shuker, 2017) and the advent of prison-based therapeutic communities as pioneered at HMP Grendon in Northamptonshire appears promising. A recent study from Saskatchewan, Canada has again shown the clear benefits of transfer from prison to a forensic hospital for involuntary treatment of serious mental illness (Adelugba et al., 2015). Post-release social and recovery support has also been shown to improve outcomes for prisoners with mental illness (Hopkin et al., 2018).

In contrast, no research from anywhere in the world has shown that involuntary treatment of mentally ill prisoners has any efficacy and there are very substantial risks whatever 'safeguards' or 'legislative oversight' are proposed.

Conclusion

In 2003, an editorial in *Psychiatry, Psychology and Law* posed the question whether it was ethically justifiable to force a prisoner to receive treatment which the prisoner was unable or unwilling to accept so that the prisoner could continue to be maintained in the stressful non-therapeutic environment of the prison? In answer to the question, one senior forensic psychiatrist in New Zealand replied emphatically: ' … the utilitarian argument of stretched resources and some clinical benefit is inadequate to argue against the objections to its use. [Concerns about] … confusion of agency, treatment to meet institutional needs rather than the needs of patients, treatment that ensures that the person remains in an aversive context and confusion of therapeutic and punitive applications of coercion, make such an application

of civil commitment improper and impractical' (Simpson, 2003). More recently, a senior forensic psychiatrist and ethicist in the United States emphasised that enforcing medication in prisons provided correctional administrators with an excuse for denying prisoners 'proper care.' Professor Felthous (2016) intoned that this 'last barrier, the indifference and acquiescence of mental health professionals themselves to the withdrawal of hospital services [was] … of greatest ethical concern.'

In 2017, the RANZCP re-iterated those concerns and emphasized that involuntary treatment of mental illness in custodial settings would compromise clinical care, encourage inappropriate management of prisoners and breach international human rights conventions. The RANZCP insisted that involuntary treatment of mental illness should only occur in appropriately designated mental health services and never in custodial environments.

For psychiatrists to acquiesce to models of care that allow the involuntary treatment of mentally ill persons in prison will also have the unintended effect of reducing the impetus to fund more inpatient beds and better resourced mental health services. The authors endorse the current position of the RANZCP that opposes any proposal for involuntary treatment of serious mental illness in prisons and advocates for the transfer of mentally ill prisoners to inpatient beds. For so many compelling reasons, psychiatrists in Australia and New Zealand should continue to advocate on behalf of mentally ill prisoners and continue to agitate for more resources and for 'best-practice' models of are to address the high burden of mental illness in this most disadvantaged population.

Disclosure statement

No potential conflict of interest was reported by the authors.

References

Adelugba, O., Mela, M., & Haq, I. (2015). 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*, *55*(2), 113–120. https://doi.org/10.1177/0025802414527048

Adily, A., Albalawi, O., Kariminia, A., Wand, H., Chowdhury, N. Z., Allnutt, S., Schofield, P., Sara, P., Ogloff, J. R. P., O'Driscoll, C., Greenberg, D., M., Grant, L. & Butler, T. (2020). Association between early contact with mental health services after an offense and reoffending in individuals diagnosed with psychosis. *Journal of the American Medical Association Psychiatry*. https://doi.org/10.1001/jamapsychiatry.2020.1255

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: Systematic review and qualitative meta-synthesis. *British Journal of Psychiatry Open*, *5*(3), 1–10. https://doi.org/10.1192/bjo.2019.19

Allison, S., Bastiampillai, T., Malhi, G. S., & Castle, D. (2019). Does early intervention prevent chronic psychosis? A question for the Victorian Royal Commission into mental health. *Australian & New Zealand Journal of Psychiatry*, *53*(10), 943–945. https://doi.org/10.1177/0004867419873717

Armour, C. (2012). Mental health in prison: A trauma perspective on importation and deprivation. *International Journal of Criminology and Sociological Theory*, *5*, 886–894.

Australian Bureau of Statistics. (2019, December 5). *Australian demographic statistics*. https://www.abs.gov.au/ausstats/abs@.nsf/mf/4517.0

Australian Bureau of Statistics. (2020, June 4). *Corrective services, Australia*. March Quarter. https://www.abs.gov.au/ausstats/abs@.nsf/mf/4512.0

Australian Health Ministers' Advisory Council. (2016, December 15). *National principles to support the goal of eliminating mechanical and physical restraint in mental health services*. https://www.mentalhealthcarersnsw.org/wp-content/uploads/2017/05/National-Principles-to-Support-the-Goal-of-Eliminating-Restraint.pdf

Australian Institute of Health and Welfare. (2019, May). *The health of Australia's prisoners*. https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/table-of-contents

Australian Institute of Health and Welfare (AIHW) (2017, October 19). *Mental health services 2016. Canberra, Australia*. Commonwealth of Australia. https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-brief-2016/contents/table-of-contents

Baranyi, G., Scholl, C., Fazel, S., Patel, V., Priebe, S., & Mundt, A. P. (2019). Severe mental illness and substance use disorders in prisoners in low-income and middle-income countries: A systematic review and meta-analysis of prevalence studies. *Lancet Global Health*, *7*(4), e461–71. https://doi.org/10.1016/S2214-109X(18)30539-4

Bennett, J., & Shuker, R. (2017). The potential of prison-based democratic therapeutic communities. *International Journal of Prisoner Health*, *13*(1), 19–24. https://doi.org/10.1108/IJPH-08-2016-0036

Brinded, P. M. J., Simpson, A. I. F., Laidlaw, T. M., Fairley, N., & Malcolm, F. (2001). Prevalence of psychiatric disorders in New Zealand prisons: A national study. *Australian & New Zealand Journal of Psychiatry*, *35*(2), 166–173. https://doi.org/10.1046/j.1440-1614.2001.00885 x

Butler, A., Young, J. T., Kinner, S. A., & Borschmann, R. (2018). Self-harm and suicidal behaviour among incarcerated adults in the Australian Capital Territory. *Health and Justice*, *6*(1), 13. https://doi.org/10.1186/s40352-018-0071-8

Butler, T., Indig, D., Allnutt, S., & Mamoon, H. (2011). Co-occurring mental illness and substance use disorder among Australian prisoners. *Drug and Alcohol Review*, *30*(2), 188–194. https://doi.org/10.1111/j.1465-3362.2010.00216.x

Chambers, M., Gallagher, A., Borschmann, R., Gillard, S., Turner, K., & Kantaris, X. (2018). The experiences of detained mental health service users: Issues of dignity in care. *BMC Medical Ethics*, *27*, 2–8.

Chang, Z., Lichtenstein, P., Larsson, H., & Fazel, S. (2015). Substance use disorders, psychiatric disorders, and mortality after release from prison: A nationwide longitudinal cohort study. *Lancet Psychiatry*, *2*(5), 422–430. https://doi.org/10.1016/S2215-0366(15)00088-7

Cochran, J. C., Toman, E. L., Mears, D. P., & Bales, W. D. (2017). Solitary confinement as punishment: Examining in-prison sanctioning disparities. *Justice Quarterly*, *35*(3), 381–411. https://doi.org/10.1080/07418825.2017.1308541

Coid, J., & Ullrich, S. (2011). Prisoners with psychosis in England and Wales: Diversion to psychiatric inpatient services? *International Journal of Law and Psychiatry*, *34*(2), 99–108. https://doi.org/10.1016/j.ijlp.2011.02.003

Coroner's Court of New South Wales. (2019, November 22). *Inquest into the death of David Dungay*. http://www.coroners.justice.nsw.gov.au/Documents/DUNGAY%20David%20-%20Findings%20-%20v2.pdf

Coyle, A. (2005). *Understanding Prisons*. Open University Press.

Cutcher, Z., Degenhardt, L., Alati, R., & Kinner, S. A. (2014). Poor health and social outcomes for ex-prisoners with a history of mental disorder: A longitudinal study. *Australian & New Zealand Journal of Public Health*, *38*(5), 424–429. https://doi.org/10.1111/1753-6405.12207

Department of Corrections New Zealand. (2019, September). *Prison facts and statistics*. https://www.corrections.govt.nz/resources/research_and_statistics/quarterly_prison_statistics/prison_stats_september_2019

Dias, S., Ware, R. S., Lennox, N. G., & Lennox, N. G. (2013). Co-occurring mental disorder and intellectual disability in a large sample of Australian prisoners. *Australian & New Zealand Journal of Psychiatry*, *47*(10), 938–944. https://doi.org/10.1177/0004867413492220

Durcan, G. (2008). *From the inside: Experiences of prison mental health care*. Sainsbury Centre for Mental Health.

Dye, M. H. (2010). Deprivation, importation, and prison suicide: Combined effects of institutional conditions and inmate composition. *Journal of Criminal Justice*, *38*(4), 796–806. https://doi.org/10.1016/j.jcrimjus.2010.05.007

Evans, C., Forrester, A., Jarrett, M., Jarrett, M., Huddy, V., Campbell, C. A., Byrne, M., Craig, T., & Valmaggia, L. (2017). Early detection and early intervention in prison: Improving outcomes and reducing prison returns. *Journal of Forensic Psychiatry & Psychology*, *28*(1), 91–107. https://doi.org/10.1080/14789949.2016.1261174

Farabee, D., Hall, E., Zaheer, A., & Joshi, V. (2019). The impact of perceived stigma on psychiatric care and outcomes for correctional mental health patients. *Psychiatry Research*, *276*, 191–195. https://doi.org/10.1016/j.psychres.2019.05.018

Favril, L., Indig, D., Gear, C., & Wilhelm, K. (2020). (2020) Mental disorders and risk of suicide attempt in prisoners. *Social Psychiatry and Psychiatric Epidemiology*. https://doi.org/10.1007/s00127-020-01851-7

Felthous, A. R. (2014). The treatment of persons with mental illness in prisons and jails: An untimely report. *Psychiatric Times*, *8*, 1–3.

Felthous, A. R. (2016). The medical ethics of hospitalizing inmates with severe mental illness. *Ethics, Medicine and Public Health*, *2*(1), 127–134. https://doi.org/10.1016/j.jemep.2016.01.009

Forrester, A., Piper, M., & Chadda, R. (2017). World psychiatric association prison public health position statement. Geneva, Switzerland: World Psychiatric Association. http://wpanet.org/uploads/Position_Statement/WPA%20Position%20Statement%20prison%20policy20fin.pdf

Forrester, A., Till, A., Simpson, A., & Shaw, J. (2018). Mental illness and the provision of mental health services in prisons. *British Medical Bulletin*, *127*(1), 101–109. https://doi.org/10.1093/bmb/ldy027

Forsyth., S. J., Carroll, M., Lennox, N., & Kinner, S. A. (2018). Incidence and risk factors for mortality after release from prison in Australia: A prospective cohort study. *Addiction*, *113*(5), 937–945. https://doi.org/10.1111/add.14106

Foulds, J. A., & Monastario, E. (2018). A public health catastrophe looms: The Australian and New Zealand prison crisis. *Australian & New Zealand Journal of Psychiatry*, *52* (11), 1019–1020. https://doi.org/10.1177/0004867418802902

Fuller, D. A., Sinclair, E., Lamb, H. R., Caye, J. D., & Snook, J. (2017). *Emptying the 'New Asylums' A beds capacity model to reduce mental illness behind bars*. Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/new-asylums

Georgiou, G., & Townsend, K. (2019). Quality network for prison mental health services: Reviewing the quality of mental health provision in prisons. *Journal of Forensic Psychiatry & Psychology*, *30*(5), 794–806. https://doi.org/10.1080/14789949.2019.1637918

Gonzales, J. M. R., & Connell, N. M. (2014). Mental health of prisoners: Identifying barriers to mental health treatment and medication continuity. *American Journal of Public Health*, *104*(12), 2328–2333. https://doi.org/10.2105/AJPH 2014.302043

Grassi, S., Mandarelli, G., Polacco, M., Vetrugno, G., Spagnolo, A. G., & De-Giorgio, F. (2018). Suicide of isolated inmates suffering from psychiatric disorders: When a preventive measure becomes punitive. *International Journal of Legal Medicine*, *132*(4), 1225–1230. https://doi.org/10.1007/s00414-017-1704-5

Green, B., Denton, M., Hefffernan, E., Russell, B., Stapleton, L., & Waterson, E. (2016). From custody to community: Outcomes of community-based support for mentally ill prisoners. *Psychiatry, Psychology and Law*, *23*(5), 798–808. https://doi.org/10.1080/13218719 2016.1152926

Haney, C. (2018). Restricting the use of solitary confinement. *Annual Review of Criminology*, *1*(1), 285–310. https://doi.org/10.1146/annurev-criminol-032317-092326

Heffernan, E., Andersen, K., Dev, A., & Kinner, S. (2012). Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons. *Medical Journal of Australia*, *197*(1), 37–41. https://doi.org/10.5694/mja11.11352

Hopkin, G., Evans-Lacko, S., Forrester, A., Shaw, J., & Thornicroft, G. (2018). Interventions at the transition from prison to the community for prisoners with mental illness: A systematic review. *Administration & Policy in Mental Health & Mental Health Services Research*, *45*(4), 623–634. https://doi.org/10.1007/s10488-018-0848-z

Hunt, E., Peters, R. H., & Kremling, J. (2015). Behavioral health treatment history among persons in the justice system: Findings from the arrestee drug abuse monitoring II program. *Psychiatric Rehabilitation Journal*, *38*(1), 7–15. https://doi.org/10.1037/prj0000132

Igoumenou, A., Kallis, C., & Coid, J. (2015). Treatment of psychosis in prisons and violent recidivism. *British Journal of Psychiatry Open*, *1*(2), 149–157. https://doi.org/10.1192/bjpo.bp.115.000257

Igoumenou, A., Kallis, C., Huband, N., Haque, Q., Coid, J. W., & Duggan, C. (2019). Prison vs. hospital for offenders with psychosis; effects on reoffending. *Journal of Forensic Psychiatry & Psychology*, *30*(6), 939–958. https://doi.org/10.1080/14789949.2019.1651381

Indig, D., Gear, C., & Wilhelm, K. (2016, June). *Comorbid substance use disorders and mental health disorders among New Zealand prisoners*. Department of Corrections.

Jacobs, L. J., & Giordano, S. N. J. (2018). "It's not like therapy": Patient-inmate perspectives on jail psychiatric services. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(2), 265–275. https://doi.org/10.1007/s10488-017-0821-2

Jordan, M. (2012). Patients'/prisoners' perspectives regarding the National Health Service mental healthcare provided in one her majesty's prison service establishment. *Journal of Forensic Psychiatry & Psychology*, *23*(5–6), 722–739. https://doi.org/10.1080/14789949 2012.733722

Joubert, D., Archambault, K., & Brown, G. (2014). Cycle of coercion: Experiences of maltreatment and disciplinary measures in Canadian inmates. *International Journal of Prisoner Health*, *10*(2), 79–93. https://doi.org/10.1108/IJPH-09-2013-0043

Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., Selling, D., MacDonald, R., Solimo, A., & Venters, H. (2014). Solitary confinement and risk of self-harm among jail inmates. *American Journal of Public Health, 104*(3), 442–447. https://doi.org/10.2105/AJPH.2013.301742

Keown, P., McKenna, D., Murphy, H., & McKinnon, I. (2019). Offenders with mental disorders in prison and the courts: Links to rates of civil detentions and the number of psychiatric beds in England – Longitudinal data from 1984 to 2016. *British Journal of Psychiatry Open*, *5*(E93), 1–7. https://doi: 10.1192/bjo.2019.73

Kinner, S. A., Preen, D., Kariminia, A., Butler, T., Andrews, J. Y., Stoove, M., & Law, M. (2011). Counting the cost: Estimating the number of deaths among recently released prisoners in Australia. *Medical Journal of Australia*, *195*(2), 64–68. https://doi.org/10.5694/j.1326-5377.2011.tb03208.x

Kolodziejczak, O., & Sinclair, S. J. (2018). Barriers and facilitators to effective mental health care in correctional settings. *Journal of Correctional Health Care*, *24*(3), 253–263. https://doi.org/10.1177/1078345818781566

Levine, H. S., & Gage, B. C. (2015). Commentary: Involuntary antipsychotics in prison—Extending Harper, contracting care? *Journal of the American Academy of Psychiatry and the Law*, *43*(2), 165–170.

Lines, R. (2006). From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons. *International Journal of Prisoner Health*, *2*(4), 269–280. https://doi.org/10.1080/17449200601069676

MacDonald, N., Hucker, S. J., & Herbert, P. C. (2010). The crime of mental illness. *Canadian Medical Association Journal*, *182*(13), 1399. https://doi.org/10.1503/cmaj.100405

McKee, J., Penn, J. V., & Koranek, A. (2014). Psychoactive medication misadventuring in correctional health care. *Journal of Correctional Health Care*, *20*(3), 249–260. https://doi.org/10.1177/1078345814532419

McKenna, B., Skipworth, J., & Pillai, K. (2017). Mental health care and treatment in prisons: A new paradigm to support best practice. *World Psychiatry*, *16*(1), 3–4. https://doi.org/10.1002/wps.20395

McKenna, B., Skipworth, J., Tapsell, R., Pillai, K., Madell, D., Simpson, A., Cavney, J., & Rouse, P. (2018). Impact of an assertive community treatment model of care on the treatment of prisoners with a serious mental illness. *Australasian Psychiatry*, *26*(3), 285–289. https://doi.org/10.1177/1039856217748247

New South Wales Inspector of Custodial Services, Department of Justice (2014, August). *Inspection standards for adult custodial services in New South Wales*. http://www.custodialinspector.justice.nsw.gov.au/Documents/Accessible%20Inspection%20Standards%20Adult.pdf

New South Wales Mental health Review Tribunal Annual Report 2018 – 2019 https://www.mhrt.nsw.gov.au/files/mhrt/pdf/MHRT%20Annual%20Report%202018%2019%20-%20Final.pdf

New Zealand Government Statistics. (2019, December). https://www.stats.govt.nz/topics/population

New Zealand Ministry of Health. (2016). Office of the director of mental health and addiction services: Annual report 2016. Wellington: Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/office-of-the-director-of-mental-health-annual-report-2016-dec17-v2.pdf

New Zealand Ministry of Health. (2019). Office of the director of mental health and addiction services: Annual report. Wellington: Ministry of Health. https://www.health.govt.nz/publication/office-director-mental-health-and-addiction-services-annual-report-2017

Niveau, G. (2007). Relevance and limits of the principle of "equivalence of care" in prison medicine. *Journal of Medical Ethics*, *33*(10), 610–613. https://doi.org/10.1136/jme.2006.018077

O'Hagan, M., Divis, M., & Long, J. (2008). Best practice in the reduction and elimination of seclusion and restraint; Seclusion: Time for change. Auckland: Te Pou Te Whakaaro Nui: The National Centre of Mental Health Research, Information and Workforce Development. https://www.tepou.co.nz/uploads/files/resource-assets/Best-Practice-in-the-Reduction-and-Elimination-of-Seclusion-and-Restraint.pdf

Ogloff, J. R. P., Pfeifer, J. E., Shepherd, S. M., & Ciorciari, J. (2017). Assessing the mental health, substance abuse, cognitive functioning, and social/emotional well-being needs of Aboriginal prisoners in Australia. *Journal of Correctional Health Care*, *23*(4), 398–411. https://doi.org/10.1177/1078345817723345

Olley, M. C., Nicholls, T. L., & Brink, J. (2009). Mentally ill individuals in limbo: Obstacles and Opportunities for providing psychiatric services to corrections inmates with mental illness. *Behavioral Sciences & the Law*, *27*(5), 811–831. https://doi.org/10.1002/bsl.899

Pratt, D., Piper, M., Appleby, L., Webb, R., & Shaw, J. (2006). Suicide in recently released prisoners: A population-based cohort study. *Lancet*, *368*(9530), 119–123. https://doi.org/10.1016/S0140-6736(06)69002-8

Queensland Health. (2018, September). *Annual report of the chief psychiatrist 2018–2019*. Queensland Health. https://www.health.qld.gov.au/__data/assets/pdf_file/0042/729969/CP-Annual-Report-2017-2018_FINAL.pdf

Queensland Health. (2019, September). *Annual report of the chief psychiatrist 2018–2019*. Queensland Health. https://www.health.qld.gov.au/__data/assets/pdf_file/0030/888051/Chief-Psychiatrists-Report-2018-19_FINAL.pdf

Quinn, C., Ryan, J., Fullam, R., & McKenna, B. (2019). 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*, *40*(7), 626–631. https://doi.org/10.1080/01612840.2019.1572845

Rangihuna, D., Kopua, M., & Tipene-Leach, D. (2018). Mahi a Atua: Pathway forward for Māori mental Health? *New Zealand Medical Journal*, *131*(1471), 79–83. https://global-uploads.webflow.com/5e332a62c703f653182faf47/5e332a62c703f694382fd708_NZMJ-1471-FINAL.pdf#page=79

Royal Australian and New Zealand College of Psychiatrists. (2016, February). *Minimising the use of seclusion and restraint in people with mental illness*. https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/minimising-the-use-of-seclusion-and-restraint

Royal Australian and New Zealand College of Psychiatrists. (2017, November). *Position statement 93. Involuntary mental health treatment in custody*. https://www.ranzcp.

org/news-policy/policy-and-advocacy/position-statements/involuntary-mental-health-treatment-in-custody

Royal Australian and New Zealand College of Psychiatrists, Faculty of Forensic Psychiatry, Victorian Branch Working Group. (2020). *Submission to Royal Commission into Victoria's Mental Health System*. https://www.ranzcp.org/membership/faculties-sections-and-networks/forensicpsychiatry/victorian-faculty-of-forensic-psych-subcommittee

Salem, A., Kushnier, A., Dorio, N., & Reeves, M. D. (2015). Nonemergency involuntary antipsychotic medication in prison: Effects on prison inpatient days and disciplinary charges. *The Journal of the American Academy of Psychiatry and the Law*, *43*(2), 159–164.

Scottish Government. (2019, October 8). *Fifth mental health and learning disability inpatient census and out of Scotland NHS placements census*. https://www.gov.scot/publications/inpatient-census-2019-part-1-mental-health-learning-disability-inpatient-bed-census-part-2-out-scotland-nhs-placements/pages/5/

Short, T., Thomas, S., Mullen, P., & Ogloff, J. R. P. (2013). Comparing violence in schizophrenia patients with and without comorbid substance-use disorders to community controls. *Acta Psychiatrica Scandinavica*, *128*(4), 306–313. https://doi.org/10.1111/acps.12066

Simpson, A. I. F. (2003). Compulsion of the detained: Service, legal and ethical issues in the use of civil commitment in correctional settings in New Zealand. *Psychiatry, Psychology and Law*, *10*(1), 108–112. https://doi.org/10.1375/pplt.2003.10.1.108

Simpson, A. I. F., & Jones, R. M. (2018). Two challenges affecting access to care for inmates with serious mental illness: Detecting illness and acceptable services. *Canadian Journal of Psychiatry*, *63*(10), 648–650. https://doi.org/10.1177/0706743718792844

Skipworth, J. (2019). The Australian and New Zealand prison crisis: Cultural and clinical issues. *Australian & New Zealand Journal of Psychiatry*, *53*(5), 839–840. https://doi.org/10.1177/0004867418817375

Spencer, D., & Dean, K. (2019). Involuntary psychiatric treatment in custody – To be unequivocally opposed or supported with safeguards and significant service improvements? *Australian & New Zealand Journal of Psychiatry*, *53*(9), 423–472. https://doi.org/10.1177/0004867419847765

State Coroner's Office and NSW Attorney General's Department. (2007, February 16). *Report by the NSW State Coroner into deaths in custody/police operations*. http://www.coroners.justice.nsw.gov.au/Documents/dic2006.pdf

State of Victoria, Royal Commission into Victoria's Mental Health System. (2019). Interim Report, Parliamentary Paper No. 87. https://rcvmhs.vic.gov.au/download_file/view_inline/2198

Stephenson, A. L., & Bell, N. (2019). Finding meaningful work in difficult circumstances: A study of prison healthcare workers. *Health Services Management Research*, *32*(2), 69–77. https://doi.org/10.1177/0951484818787698

Sugiura, K., Mahomed, F., Saxena, S., & Patel, V. (2020). An end to coercion: Rights and decision-making in mental health care. *Bulletin of the World Health Organisation*, *98*(1), 52–58. https://doi.org/10.2471/BLT.19.234906

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *British Journal of Psychiatry Advances*, *24*, 319–333.

Thomas, E. G., Spittal, M. J., Heffernan, E. B., Taxman, F. S., Alatis, R., & Kinner, S. A. (2016). Trajectories of psychological distress after prison release: Implications for mental health service need in ex-prisoners. *Psychological Medicine*, *46*(3), 611–621. https://doi.org/10.1017/S0033291715002123

Thomas, E. G., Spittal, M. J., Taxman, F. S., & Kinner, S. A. (2015). Health-related factors predict return to custody in a large cohort of ex-prisoners: New approaches to predicting reincarceration. *Health & Justice*, *3*(1), 1–13. https://doi.org/10.1186/s40352-015-0022-6

Till, A., Forrester, A., & Exworthy, T. (2014). The development of equivalence as a mechanism to improve prison healthcare. *Journal of the Royal Society of Medicine*, *107*(5), 179–182. https://doi.org/10.1177/0141076814523949

Torrey, E., Zdanowicz, M., Kennard, A., Lanb, H. R., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2014, April 8). *The treatment of persons with mental illness in prisons and jails: A State Survey*. Treatment Advocacy Center. www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatmentbehind-bars.pdf

Tyler, N., Miles, H. L., Karadag, B., & Rogers, G. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: Prevalence, comorbidity, and gender differences. *Social Psychiatry and Psychiatric Epidemiology*, *54*(9), 1143–1152. https://doi.org/10.1007/s00127-019-01690-1

United Kingdom Department for Health and Social Care. (2018). Modernising the Mental Health Act: Increasing choice, reducing compulsion. Final report of the independent review of the Mental Health Act 1983. London: Department for Health and Social Care. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762206/MHA_reviewFINAL.pdf.

United Kingdom Department of Health. (2014, April). *Social care and local government and care partnership directorate, positive and proactive care: Reducing the need for restrictive interventions*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

United Nations. (2007) *Convention on the rights of persons with disabilities*. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html.

United Nations. (2015, December). *Standard minimum rules for the treatment of prisoners*. https://undocs.org/A/RES/70/175.

Victorian Auditor-General. (2019, March). Access to Mental Health Services. Melbourne, Australia. https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf

Victorian Institute of Forensic Mental Health (Forensicare). (2019, August). *Annual report 2018–19*. Retrieved from https://www.forensicare.vic.gov.au/wp-content/uploads/2019/10/201910-FC-Annual-Report-2018-19-FINAL-WEB.pdf

Vine, R. (2019, June 27). *Witness statement of Ruth Geraldine vine to royal commission into Victoria's mental health system*. https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/8015/6265/6755/Dr_Ruth_Vlne.pdf

World Health Organization. (2007, October 8). *Trencín statement on prisons and mental health*. http://www.euro.who.int/__data/assets/pdf_file/0006/99006/E91402.pdf?ua=1

Wright, N., Jordan, M., & Kane, E. (2014). Mental health/illness and prisons as place: Frontline clinicians' perspectives of mental health work in a penal setting. *Health and Place*, *29*, 179–185. https://doi.org/10.1016/j.healthplace 2014.07.004

Young, J. T., Heffernan, E., Borschmann, R., Ogloff, J. R. P., Spittal, M. J., Kouyoumdjian, F. G., ., Preen, D. B., Butler, A., Brophy, L., Crilly, J., & Kinner, S. A. (2018). Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: A prospective cohort study. *Lancet Public Health*, *3*(5), 237–248. https://doi.org/10.1016/S2468-2667(18)30052-5

Position Statement 93

Involuntary mental health treatment in custody

November 2017

The Royal Australian & New Zealand College of Psychiatrists

Authorising Committee/Department:	Board
Responsible Committee/Department:	Faculty of Forensic Psychiatry
Document Code:	**PS93 PPP Involuntary mental health treatment in custody**

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.

Key messages

- The RANZCP opposes the use of involuntary mental health treatment in custodial settings.
- If a prisoner experiences psychiatric symptoms so severe that involuntary treatment is necessary, the RANZCP believes that the prisoner should be transferred to receive treatment in a hospital.
- The RANZCP opposes the use of Treatment Orders for prisoners, except where this occurs to ensure prisoners are transferred out of prison to receive care in an appropriate facility.
- The RANZCP considers that involuntary mental health treatment in custodial settings compromises clinical care, encourages inappropriate management of prisoners, and breaches human rights.
- Given the very high prevalence of mental illness among prisoners, the RANZCP advocates greater investment in prisoner mental health services, and the increased use of alternatives to involuntary treatment in custody.

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,[2] 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

[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).

[2] *Crimes (Administration of Sentences) Act 1999* (NSW) s73(1); *Corrective Services Act 2006* (Qld) s21(1); *Prisons Act 1981* (WA) s95D(d); *Correctional services Act* (NT) s92; SA Health (2014) *Prisoners – Care and Treatment in SA Health Services*. Adelaide, South Australia: SA Health, 5.

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 non-offender 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.

References

Australian Bureau of Statistics (2015) Prisoners in Australia 2015. Canberra, Australia: Australian Bureau of Statistics.

Australian Health Ministers' Advisory Council (2006) National Statement of Principles for Forensic Mental Health. Available at: mhsa.aihw.gov.au/committees/publications (accessed 7 November 2016).

Butler T, Andrews G, Allnutt S, Sakashita C, Smith NE, Basson J (2006) Mental Disorders in Australian Prisoners: a Comparison with a Community Sample. Australian and New Zealand Journal of Psychiatry 40(3): 272–6.

Correctional Services Act 2014 (NT) s 92.

Corrections Act 2006 (NZ) s 75.

Corrective Services Act 2006 (Qld) s 21(1).

Crimes (Administration of Sentences) Act 1999 (NSW) s 73(1).

Ministry of Health New Zealand (1988) Report of the Committe of Inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patient ['The Mason Report']. Wellington, New Zealand: Ministry of Health New Zealand.

Morgan RD, Flora DB, Kroner DG, Mills JF, Varghese F, Steffan JS (2012) Treating Offenders with Mental Illness: A Research Synthesis. Law and Human Behavior 36: 37–50.

Ogloff J (2015) Good mental health care in prisons must begin and end in the community. Available at: theconversation.com/good-mental-health-care-in-prisons-must-begin-and-end-in-the-community-40011 (accessed 1 December 2016).

Prisons Act 1981 (WA) s 95D(d).

Radio New Zealand (2017) NZ use of Seclusion in prison lambasted. Available at: www.radionz.co.nz/news/national/329557/nz-use-of-seclusion-in-prison-lambasted (accessed 2 May 2017).

SA Health (2014) Prisoners – Care and Treatment in SA Health Services. Adelaide, South Australia: SA Health, 5.

Statistics New Zealand (2012) New Zealand's prison population. Available at: www.stats.govt.nz/browse_for_stats/snapshots-of-nz/yearbook/society/crime/corrections.aspx (accessed 1 December 2016).

Sydney Morning Herald (2012) Revealed: Mentally Ill Prisoners wait a year for treatment. Available at: www.smh.com.au/nsw/revealed-mentally-ill-prisoners-wait-a-year-for-treatment-20120320-1vi1x.html (accessed 1 December 2016).

Sullivan D, Mullen P (2012) Mental health and Human Rights in Secure Settings. In Dudley, Silove and Gale (eds) Mental Health and Human rights: vision, praxis and courage (2012) Oxford, United Kingdom: Oxford University Press.

United Nations Convention on the Rights of Persons with Disabilities (entry into force 3 May 2008).

United Nations General Assembly. Standard Minimum Rules for the Treatment of Prisoners (2015) E/CN.15/2015/L.6/Rev.1.

United National General Assembly. Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) GA Res, A/RES/46/119. .

Victoria Department of Justice and Regulation (2015) Aboriginal Social and Emotional Wellbeing Plan. Melbourne, Victoria: Victoria Department of Justice and Regulation.

Victorian Ombudsman (2014) Investigation into deaths and harm in custody. Available at: www.ombudsman.vic.gov.au/Publications/Parliamentary-Reports/Investigation-into-deaths-and-harm-in-custody (accessed 1 November 2016).

Victorian Ombudsman (2015) Investigation into the rehabilitation and reintegration of prisoners in Victoria. Available at: www.ombudsman.vic.gov.au/getattachment/5188692a-35b6-411f-907e-3e7704f45e17 (accessed 1 December 2016).

Western Australian Ombudsman (2000) Report on an investigation into deaths in prisons. Available at: www.ombudsman.wa.gov.au/Publications/Documents/reports/deathsinprisons/2000-Full-Report-on-Deaths-in-prisons.pdf (accessed 1 November 2016).

World Health Organization (2007) Trencín statement on prisons and mental health. Available at: www.euro.who.int/__data/assets/pdf_file/0006/99006/E91402.pdf (accessed 1 November 2016).

World Health Organization (2014) Prisons and health. Available at: www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf (accessed 1 December 2016).

Disclaimer

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

REVISION RECORD

Contact:	Executive Department Manager, Practice, Policy and Partnerships		
Date	**Version**	**Approver**	**Description**
11/2017	1.0	B2017/7 R12	New document
11/2020			**NEXT REVIEW**

SECURITY CONDITIONS PROTOCOL
(section 76D of the *Mental Health (Forensic Provisions) Act 1990*)

BETWEEN

DIRECTOR-GENERAL, NSW DEPARTMENT OF HEALTH

AND

COMMISSIONER OF CORRECTIVE SERVICES

IN RELATION TO

FORENSIC PATIENTS AND CORRECTIONAL PATIENTS

Date: **2011**

1. PARTIES

1.1 Director-General, NSW Department of Health

1.2 Commissioner of Corrective Services

2. APPLICATION OF THE PROTOCOL

2.1 This Protocol affects the operations of agencies in addition to the NSW Department of Health (DOH) and Corrective Services NSW (CSNSW), including Justice Health and Local Health Networks, when they provide health care to correctional patients and forensic patients. These affected agencies are listed in Schedule A to this Protocol.

3. DEFINITIONS

3.1 ***Correctional patient*** means a correctional patient as defined in section 41 of the *Mental Health (Forensic Provisions) Act 1990.*

3.2 ***Corrective Services NSW*** (CSNSW) means that part of the Department of Justice and Attorney General comprising the group of staff who are principally involved in the administration of the *Crimes (Administration of Sentences) Act 1999.*

3.3 ***Department of Health ("DOH")*** means the NSW Government Department specified as such in Schedule 1 of the *Public Sector Employment and Management Act 2002.*

3.4 ***Forensic Hospital*** means a new purpose-built high security psychiatric hospital that is administered by Justice Health. It is a declared mental health facility under s. 109 of the *Mental Health Act 2007* and is located outside the Long Bay Prison Complex.

3.5 ***Forensic patient*** means a forensic patient as defined in section 42 of the *Mental Health (Forensic Provisions) Act 1990.*

3.6 ***Inmate*** has the same meaning as in s. 3 of the *Crimes (Administration of Sentences) Act 1999* and includes a juvenile inmate and section 28 juvenile inmate as defined in s. 41A of the *Crimes (Administration of Sentences) Act 1999.*

3.7 ***Justice Health*** means the statutory health corporation constituted by section 41 of the *Health Services Act 1997* and specified in Schedule 2 of that Act.

3.8 ***Local Health Network*** means a local health network constituted under section 17 of the *Health Services Act 1997* and specified from time to time in Schedule 1 to that Act.

3.9 ***NSW Health*** has the meaning given in s4 of the *Health Administration Act 1982.*

4. SECURITY CONDITIONS

4.1 Security conditions that apply to a forensic patient detained in a correctional centre or any part of a correctional centre that is a mental health facility

4.1.1 CSNSW is responsible for the security conditions that apply to a forensic patient detained in a correctional centre.

4.1.2 CSNSW recognises that a forensic patient has a right to health care and will allow all forensic patients timely access to health services. Where a security requirement

might impinge upon access to health treatment, CSNSW staff will inform the senior Justice Health nurse on duty and discuss the matter with that nurse.

4.2 Security conditions that apply to a correctional patient detained in the Forensic Hospital

4.2.1 A correctional patient who is detained in the Forensic Hospital is subject to security controls and policies set down by Justice Health.

4.2.2 In most cases, CSNSW officers will not be required to supervise a correctional patient once he or she has been admitted to the Forensic Hospital. In exceptional cases, where CSNSW considers more security is appropriate, CSNSW officers may supervise a correctional patient in the Forensic Hospital in accordance with an agreement between CSNSW and Justice Health specific to that patient.

4.2.3 DOH agrees that in regards to section 76E(1) of the *Mental Health (Forensic Provisions) Act 1990,* before making any order to transfer a forensic patient to or from a mental health facility that is within the confines of a correctional centre or to transfer a correctional patient, the Director-General of the DOH will consider matters of security, including any security concerns expressed by the Commissioner of CSNSW.

4.2.4 In exceptional circumstances as determined by the Commissioner of CSNSW, after consultation with the Chief Executive of Justice Health, CSNSW may be responsible for the following security procedures in respect of correctional patients detained in the Forensic Hospital:

(a) approving all visitors to a correctional patient. Any refused visitors are to be reported to the Chief Executive of Justice Health or delegate;

(b) approving certain items of incoming mail received and outgoing mail sent by a correctional patient. In these circumstances mail may be redirected through correctional centres to ensure that appropriate safety and security procedures are followed; and

(c) approving all telephone requests made by a correctional patient.

4.3 Security conditions that apply to persons the subject of a transfer order under section 55 of the MHFP Act, correctional patients, and forensic patients while they are being transferred

4.3.1 CSNSW will arrange the following transfers of persons the subject of a transfer order under section 55 of the MHFP Act and provide appropriate supervision and transport for:

(a) a person the subject of a transfer order under section 55 of the MHFP Act from a correctional centre to a hospital or some other place for medical treatment in accordance with an order made by the Commissioner of CSNSW; and

(b) a person the subject of a transfer order under section 55 of the MHFP Act from a correctional centre to the Forensic Hospital or any mental health facility within the confines of a correctional centre, in accordance with an order made by the Director General of DOH or the Mental Health Review Tribunal or a court.

4.3.2 CSNSW will arrange the following transfers of correctional patients, and provide appropriate supervision and transport to:

(a) a correctional patient from the Forensic Hospital or from any mental health facility within the confines of a correctional centre, to a correctional centre, in accordance with an order made by the Director-General of DOH or the Mental Health Review Tribunal or a court. Only the Commissioner of Corrective Services or his authorised delegate can determine placement in a specific correctional centre, once an order is made that a correctional patient may be discharged;

(b) a correctional patient from the Forensic Hospital or any mental health facility within the confines of a correctional centre to court in accordance with an order made by a court, subject to a prior clinical assessment by Justice Health being carried out and the correctional patient being considered fit to attend court. Wherever possible the parties agree that video conferencing should be arranged rather than transport to court.

(c) a correctional patient from court to the Forensic Hospital or to any mental health facility within the confines of a correctional centre in accordance with an order made by a court;

(d) in exceptional circumstances as determined by the Commissioner of CSNSW in consultation with Justice Health, a correctional patient between mental health facilities including between the Forensic Hospital and other mental health facilities in accordance with an order made by the Director-General of DOH or the Mental Health Review Tribunal or a court; and

(e) in exceptional circumstances as determined by the Commissioner of CSNSW, a correctional patient from a mental health facility **not** within the confines of a correctional centre or the Forensic Hospital back to the Forensic Hospital or a mental health facility within the confines of a correctional centre or a correctional centre in accordance with an order made by the Director-General of DOH or the Mental Health Review Tribunal.

4.3.3 CSNSW will arrange the following transfers of forensic patients and provide appropriate supervision and transport to:

a) a forensic patient from a correctional centre or from any mental health facility within the confines of a correctional centre to a hospital or some other place for medical treatment in accordance with an order made by the Commissioner of CSNSW;

b) a forensic patient from a correctional centre to the Forensic Hospital or to any mental health facility within the confines of a correctional centre in accordance with an order made by the Director-General of DOH or the Mental Health Review Tribunal or a court; and

c) a forensic patient from the Forensic Hospital or from any mental health facility within the confines of a correctional centre to a correctional centre in accordance with an order made by the Director-General of DOH or the Mental Health Review Tribunal or a court. Only the Commissioner of CSNSW or his authorised delegate can determine placement in a specific correctional centre, once an order is made that a forensic patient may be discharged.

4.3.4 When a forensic patient detained in the Forensic Hospital is required to attend court, Justice Health will arrange the transport of, forensic patients during their required attendance at court. CSNSW will only assist in the provision of supervision of the forensic patient whilst at court.

4.3.5 Subject to any order of a court, Justice Health and CSNSW will work co-operatively, on a case by case basis, to identify options and arrange appropriate transport of, and

to provide security during any transport, of a forensic patient ordered by the court to be detained in a mental health facility following the finding of not guilty by reason of mental illness or the imposition of a limiting term under the *Mental Health (Forensic Provisions) Act 1990.* This however applies to CSNSW only if such forensic patient was a person already in the custody of CSNSW when they attended court and the court made an order making that person a forensic patient.

4.3.6 Justice Health or, where appropriate, NSW Health will arrange the following transfers of correctional patients, and provide appropriate supervision and transport:

a) a correctional patient from the Forensic Hospital to a hospital or other place for the purposes of medical appointments, medical treatment or any other lawful purpose, unless a combined risk assessment undertaken by Justice Health and CSNSW indicates that this would present an unacceptable security risk in which case CSNSW will arrange the transfer and provide appropriate supervision and transport;

b) all forensic patients other than those transfers referred to in 4.3.3, 4.3.4 and 4.3.5.

4.3.8 Prior to CSNSW transferring a correctional patient from the Forensic Hospital, CSNSW will consult with Justice Health staff to ascertain whether any health issues may affect the transport of the patient and whether a nurse escort is necessary.

4.4 Mental Health Facilities other than the Forensic Hospital and a mental health facility within the confines of a correctional centre

4.4.1 The parties recognise that an order under section 55 of the *Mental Health (Forensic Provisions) Act 1990* ordering an inmate to be transferred to and detained in a mental health facility other than the Forensic Hospital or a mental health facility inside a correctional centre should only occur in exceptional circumstances. Factors that may be considered in determining whether exceptional circumstances exist include:

a) where, owing to distance considerations, it is not reasonable to transfer an inmate to the Forensic Hospital or a mental health facility inside a correctional centre; and
b) where the medical condition of the inmate requires acute attention and the severity of the patient's condition would make it unreasonable to transfer the inmate to the Forensic Hospital or a mental health facility inside a correctional centre; and
c) the length of time in which the inmate is expected to be detained in a mental health facility.

4.4.2 Where, owing to exceptional circumstances, an order is made under section 55 of the *Mental Health (Forensic Provisions) Act 1990* ordering an inmate to be transferred to and detained in a mental health facility other than the Forensic Hospital or a mental health facility inside a correctional centre, CSNSW will arrange the transfer of an inmate the subject of an order under section 55 of the *Mental Health (Forensic Provisions) Act 1990*, and provide security while detained in a mental health facility other than the Forensic Hospital or a mental health facility inside a correctional centre.

4.4.3 The parties further recognise that any transfer of a correctional patient under s76E of the *Mental Health (Forensic Provisions) Act 1990* to a mental health facility other than the Forensic Hospital or a mental health facility inside a correctional centre should only occur in exceptional circumstances where it is not reasonable to continue to treat the patient in the Forensic Hospital or a mental health facility inside a correctional centre.

4.4.4 Where a correctional patient is ordered to be transferred to, and detained in, either:

(a) a mental health facility *other than* the Forensic Hospital; or

(b) a mental health facility within the confines of a correctional centre;

the following matters will be determined on a case-by-case basis between the Commissioner of CSNSW and the Medical Superintendent of the mental health facility concerned:

(i) the agency responsible for any transfer to and from that mental health facility; and

(ii) the agency responsible for supervision during such a transfer, including any subsequent other lawful transports, such as to and from court; and

(iii) the agency responsible for providing security of the patient while being transferred and detained.

In regards to (iii) above, the Commissioner of CSNSW and the Director-General of DOH will consult, as required, in order to determine the applicable security conditions to be imposed upon a patient, where that transport is being undertaken by staff of CSNSW.

4.5 Security conditions that apply to a correctional patient who is granted leave of absence from a mental health facility

4.5.1 Despite any clause in this Part, the security conditions that apply to a correctional patient will be those specified in the order made by the Director-General of DOH or the Commissioner of CSNSW as the case may be.

4.5.2 If a correctional patient is granted leave of absence from a mental health facility, in accordance with s. 63 of the *Mental Health (Forensic Provisions) Act 1990*, the delegate of the Director-General of DOH who granted the leave of absence will notify the correctional centre from which the patient was originally transferred as soon as possible prior to, or in a medical emergency after, the making the order granting leave of absence.

5. REVIEWS

5.1 NSW Health and CSNSW will review this Protocol from time to time as necessary.

6. VARIATIONS

6.1 Any variations to this Protocol must be agreed, recorded in writing and signed by both the Director-General of DOH and the Commissioner of CSNSW. Any variations that are not so documented and signed will have no effect.

7. REPORTING REQUIREMENTS AND CO-OPERATION BETWEEN PARTIES

7.1 DOH and CSNSW will each nominate a liaison officer who will have responsibility for facilitating effective management of this Protocol and the resolution of issues which may arise from this Protocol.

8. JOINT OBLIGATIONS

8.1 Subject to this Protocol, DOH and CSNSW agree to do all things reasonably necessary and execute all documents required to obtain, facilitate and to give effect to each party's obligations pursuant to this Protocol.

9. FUNCTIONS OF COMMISSIONER OF CSNSW

9.1 Nothing in the *Mental Health (Forensic Provisions) Act 1990* or any order made under that Act, or this Protocol, prevents the Commissioner of CSNSW from exercising (or limits the exercise of) a function in relation to a forensic patient or a correctional patient who is detained on or in a correctional complex, a correctional centre or a residential facility as may be declared under the *Crimes (Administration of Sentences) Act 1999 NSW* if the function is exercised for the purpose of maintaining the personal safety of any person or the security of a correctional complex, a correctional centre or a residential facility or good order and discipline within the correctional environment.

9.2 Where appropriate, the Commissioner of CSNSW may delegate any of his functions (other than this power of delegation) in relation to any matters set out in this Protocol.

10. SIGNATURE

Signed by: Professor Debora Picone AM, Director-General, NSW Department of Health

Signature: …….. Date: ……..

Signed by: Ron Woodham, Commissioner of Corrective Services NSW

Signature: …….. Date: ……..

SCHEDULE A – AFFECTED AGENCIES

1. Justice Health
2. Forensic Mental Health Network
3. Sydney Local Health Network
4. South Western Sydney Local Health Network
5. South Eastern Sydney Local Health Network
6. Illawarra Shoalhaven Local Health Network
7. Western Sydney Local Health Network
8. Nepean Blue Mountains Local Health Network
9. Northern Sydney Local Health Network
10. Central Coast Local Health Network
11. Hunter New England Local Health Network
12. Murrumbidgee Local Health Network
13. Southern NSW Local Health Network
14. Western NSW Local Health Network
15. Far West Local Health Network
16. Mid North Coast Local Health Network
17. Northern NSW Local Health Network