Should we allow compulsory mental health treatment in prisons?

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In my more grandiose moments, it occurs to me that the various reports and policy documents that we deal with every day will form part of the source materials for future historians. It would be nice to think that our own age will be studied by someone as indefatigable and brilliant as Roy Porter, whose death earlier this year robbed us of our best commentator to date on the social history of psychiatry. I looked forward to each of his books and it is sad that there will be no more.[1]

I have a tip for the future scholars who unearth dusty copies of this journal. Assuming that future generations remember that one of the best ways to examine a society is through its treatment of its most vulnerable members, they could do worse than to turn their attention to one report, already two years old, called *Nursing in Prisons*.[2]

They should turn to the concise and restrained Chapter 18, entitled "Concerns about Secondary Mental Health Care in Prisons". While acknowledging that nurses and healthcare officers do their best within current arrangements, this chapter states that "prison health care does not and can not provide" adequate secondary level mental health care (para 85). The report's description of what actually happens to mentally disordered prisoners falls between the lines of the same paragraph: "we are concerned about the practice of keeping disturbed prisoners with mental health problems alone in their cells for long periods of time. We are particularly concerned about the level of care provided at night… in the NHS, seclusion is used only as a last resort under the direction of a psychiatrist following strict protocols".

What is being tacitly acknowledged in the above is that some seriously disturbed prisoners with mental disorder are routinely subject to conditions of isolation and standards of care that would be considered unethical and scandalous outside prison. Our future historians will not be kind to us on that score.

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1 *I particularly recommend 'Mind-Forg'd Manacles: A history of madness in England from the Restoration to the Regency' (1987), 'A Social History of Madness' (1996) and 'Madness: A brief history' (2002).*

2 *Nursing in Prisons: Report by the Working Group considering the development of prison nursing, with particular reference to health care officers. Department of Health 2000. This document, alongside most of the others relating to prison healthcare mentioned below, is available online at www.doh.gov.uk/prisonhealth.*

The *Nursing in Prisons* working group recommended that the management of prisoners with significant mental health problems should accord with the strict guidelines that pertain in the NHS, whether this takes place on the prison premises or through transfer to NHS facilities outside.[3] Previous official statements had already recognised that the historic isolation of prison healthcare from the NHS had raised questions of equity and standards of care.[4] The *Nursing in Prisons* report found that facilities within prison healthcare centres were not equivalent to those outside because of lack of staff and expertise, unsuitable environments and inadequate levels of observation and treatment.[5]

Developments in Prison Health Care.

At the time of the *Nursing in Prisons* report there was already a policy shift towards formal partnership between the NHS and the Prison Service for the provision of prison healthcare as a whole. This partnership is now set to evolve into the wholesale transfer of prison health into the NHS over the next five years.[6] In the meantime various measures are intended to develop far more sophisticated mental health services in prisons than are generally available at present. The NHS Plan promises additional staff and more comprehensive treatment.[7] The National Service Frameworks for Mental Health operative in England and Wales encompass the care of prisoners.[8] By 2004, upon release all prisoners with serious mental disorders should have in place care plans overseen by care co-ordinators. By the time this article is published, all prisons should have completed a service review in collaboration with local NHS services and should have action plans in place for identified needs.[9]

The basic principle underlying the changes in prison healthcare is that, allowing for the prison context, services should be provided as far as possible in the same way as they are in the wider community.[10] Therefore, just as the focus of service development outside prisons is on community-based services, so the focus within prisons is on mental health promotion and "wing-based" mental health interventions. A key target over the next 3 – 5 years has been set as reducing the numbers of prisoners resident in prison-based health care centres, with resources re-deployed to day care and wing-based services.[11]

One way of managing this, and perhaps the most dramatic change in service provision within prisons, will be the establishment of NHS managed "in-reach" teams in around half (60–70 out of 137) of the prisons in England and Wales over the next two years.[12] By 2006 all prisons should have some form of in-reach services.[13] "In-reach" services for prisons are likely to play a broader role than their community-based "out-reach" counterparts. Whereas out-reach services' role is to help those with

3 *Ibid, para 86*

4 *'The Future Organisation of Prison Health Care: Report by the Joint Prison Service and National Health Service Executive Working Group'. HM Prison Service & NHS Executive 1999.*

5 *'Nursing in Prisons', para 86*

6 *`Prison Health Transferred to Department of Health', Department of Health Press Release 64N/02 (24 September 2002)*

7 *`The NHS Plan: a plan for investment, a plan for reform' Cm 4818-I. Department of Health 2000.*

8 *`National Service Framework for Mental Health. Modern standards and service models' Department of Health 1999; `Adult Mental Health: a National Service Framework' National Assembly for Wales 2002.*

9 *`Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons' Department of Health, HM Prison Service & The National Assembly for Wales 2001, para 6.*

10 *ibid, para 4.7*

11 *ibid, para 10*

12 *ibid, para 4.8*

13 *'Mental Health Bill Consultation Document' Cmnd 5538-III. Department of Health 2002, para 3.34.*

serious mental illness stay in contact with specialist services, "in-reach" services will eventually be expected to provide general mental health services suited to all patients with mental health needs.[14]

Extending compulsory powers into prison

At present, the powers to provide compulsory treatment under the Mental Health Act 1983 are not applicable inside prisons, where any treatment without consent must be justified under the common law. The Department of Health has produced guidance on the use of such common law powers in prison.[15] The only power available in respect of prisoners under the Mental Health Act 1983 is that which allows their transfer from the prison environment to hospital facilities where compulsory care and treatment under the Act's powers are applicable.[16] There are often delays in the transfer process, particularly while a suitable bed is identified and made available. The Prison Health Policy Unit now has a protocol for transfer delays of longer than three months.[17] Three months is a long time to provide inadequate care to an acutely disturbed person.

Perhaps unsurprisingly, the government has questioned whether it is time to consider extending powers of compulsion to prison environments. The government's consultation document on its draft Mental Health Bill set out a simple argument for such an extension. It reasoned that, just as the draft Bill would provide a framework for the compulsory treatment in the community, thus severing the present law's link between compulsion and detention in hospital, so "there should be similar flexibility for patients to receive compulsory treatment in prison".[18] Community treatment orders, in this model, would be allowed through the prison gates, so that prisoners could be made subject to them "just as if [they] were not in prison".[19]

The consultation document did allow that "NHS services for prisoners still have some way to go before compulsory treatment as outlined here could be provided in every prison". Therefore, the law would allow for compulsion only when appropriate services are in place and conditions are right.[20] It did not set out what such conditions should be, but the parallel drawn between the use of compulsion in the community and prison, and the specific mention of in-reach service development, gave a broad hint at some sort of "wing-based" service.

In its response to the draft Mental Health Bill,[21] the Mental Health Act Commission has challenged the view that powers equivalent to "community treatment orders" should be used within prisons.

It is clear that, for compulsory treatment within prisons to be legally or ethically justifiable, the level of service provision and support available to prisoner-patients should be at least equivalent to that which would be available elsewhere. It is less clear that in-reach services of any kind can provide the levels of service appropriate to provide compulsory mental health treatment. The prison "community" cannot offer any real equivalent to the support and care available outside prison, and any assumed equivalence between prison and the community outside greatly underestimates the isolation of the mentally ill in prison, the stigma of mental illness in such a situation and the bullying that can go on.

14 *`Changing the Outlook' para 4.7*

15 *`Seeking Consent: Working with People in Prison' Department of Health & HM Prison Service 2002.*

16 *Mental Health Act 1983, sections 47 – 53.*

17 *'Prison Health Newsletter, Summer 2002' Department of Health, HM Prison Service & The National Assembly for Wales 2002, page 10*

18 *Mental Health Bill Consultation Document para 3.35*

19 *ibid, para 3.36*

20 *ibid, para 3.40*

21 *Response to the Draft Mental Health Bill. Mental Health Act Commission 2002. Available online at www.mhac.trent.nhs.uk*

The Commission was therefore concerned that some form of dispensary-style system of compulsion in prisons was being considered by the Government. We took the view that, if a prisoner-patient is suffering with a mental disorder to a degree that requires intervention without consent, a higher priority should be to ensure that he or she is cared for in proper surroundings and is not spending every night, and perhaps most of every day, in effective seclusion in a cell.

This is not to say that the use of compulsion should not be contemplated within the prison environment. If appropriate treatment units were available within prisons, it would make sense to allow compulsory treatment there. Such units should, in the Commission's view, be equivalent facilities to in-patient units outside of prison. They should be separate from the normal residential accommodation, staffed at all times with NHS professionals and able to provide the necessary treatment under the same quality-assurance arrangements (such as professional regulation and inspection of services) as exist elsewhere in the NHS. We would also expect the same safeguards to be available to prisoner-patients as would be available to patients subject to compulsion outside prison, such as the oversight of a monitoring body, access to advocacy, ability to appeal against compulsion to a tribunal and to have tribunal oversight and safeguards applied to the treatment itself.

Even if this infrastructure was in place, there should still be a requirement that transfer to an outside hospital should be considered if that would be in the prisoner-patient's best interests. The provision of compulsory treatment in prisons should not be allowed to create a disincentive for transfers to NHS care in hospitals outside where this is clinically or socially appropriate.

The conditions determining a clinical threshold for the use of compulsion under a Mental Health Act in prison need be no different to those that operate outside, but the overriding condition for the use of compulsion should be the removal of the prisoner-patient to a designated treatment environment for the duration of that treatment. Such placement would, in our view, be appropriate irrespective of whether the patient would, if outside of prison, have been assessed as requiring a residential or non-residential treatment order. The particular conditions of prison life are such that we feel this difference in approach would be justified, even though it means that the same presentation that, outside prison, would warrant only a non-residential order would, in prison, warrant residential care. The issue at stake in prison is the invasion of bodily autonomy, rather than the deprivation of liberty.

We feel that such a solution would provide a welcome extension of legal safeguards across this relatively unregulated area of medical care and *de facto* compulsion. It is not, however, a quick fix, and it does not sit comfortably with the Government's very understandable priorities around primary care in prisons.[22] This undoubtedly means, in the Commission's view, that transfer from prison to a hospital environment must remain the primary and preferred option for all prisoners who would, if outside prison, fall within the criteria of the 1983 Act or subsequent legislation. The alternative, which is the introduction of compulsory powers into an ill-prepared healthcare system, would be an irresponsible wielding of power and would be unlikely to benefit the prisoner-patients concerned. And posterity will be watching.

22 *'Developing and Modernising Primary Care in Prisons'. Department of Health, HM Prison Service & The National Assembly for Wales 2002.*