

Office of the Public Advocate

**A rights based approach to the planning of mental health services  
for the prison population**

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I wish to acknowledge the Kurna people as the traditional owners of this land, and the links to this land of the Kurna people of today.

In this presentation I wish to consider key rights based concerns, in the planning and operation of mental health services for prisoners. First by quickly noting key fundamental human rights and how they should apply to this population, and then second considering in more detail the Convention against Torture and Cruel and Inhuman Treatment and Punishment. This year Juan Mendez the Special Rapportuer for this convention has made a key statement on abuse in health care settings, that is relevant to mental health and disability care generally, but can also be applied to Correctional settings.

Also it is expected that Australia will sign the Optional Protocol for this Convention, which will make it enforceable, and open detention settings up to a more robust set of mechanisms that will prevent restraint and seclusion.

First, fundamental rights must be upheld for people in prison - civil and political rights **and** economic, social and cultural rights.

Articles 7 and 10 of the International Covenant on Civil and Political Rights (ICCPR) requires that no one be subject to cruel, inhuman and degrading treatment or punishment, and the inherent dignity of all humans be respected. For this to happen an essential aim of the treatment of people in prison must be reformation and social rehabilitation. General Comment 21 relevant to these rights recognises that persons deprived of their liberty will enjoy all rights set forth in the covenant subject to the restrictions that are unavoidable in a closed environment.

It is highly unlikely that a mentally unwell person in prison can be treated in a respectful and humane way if necessary treatment is not provided to manage both personal distress and behavioural problems using a clinical and therapeutic approach.

With respect to the Convention on Economic, Social and Cultural Rights (CESCR), Article 12 of that convention recognises the right of everyone to the enjoyment of the highest standard of physical and mental health. This applies to prisoners.

## Equivalence of service provision

Australia's national statement of Principles for Forensic Mental Health has a key principle of service equivalence to the non-offender. Using this principle an offender should expect to receive the same services as a member of the community.

Using this as a benchmark it is then possible to apply the same population based planning approaches that are used in the general population to the prison population to define the necessary mix of services and their volume.

This can apply to each level of service provision: primary, secondary and tertiary. I will just run through some examples. Compared to the services we have now, these descriptions of what services should be available might sound idealistic, but they shouldn't be seen this way. What is being promoted is equivalence to what is available in the community which in itself has gaps.

So with respect to primary health care, Mental health promotion, prevention and early intervention services should be provided; provided by prison authorities, and prison health. All prison officers need mental health first aid at the very least, or some other training.

With respect to specialist services, people who use specialist community mental health services when out of prison, should get those services in prison – such as seeing a mental health case worker and a treating psychiatrist. Just to make the point, if a heart patient needs to see a cardiologist regularly in the community and then is imprisoned, that heart patient will get to see a specialist while they are a prisoner. Mental health is no different even if appointments with mental health staff may need to be more regular.

For all this to happen prison in reach has to be more than just clinics by psychiatrists and psychologists, but inreach by a mental health team, so that all clinical mental health disciplines can contribute.

If access is required to specialist inpatient forensic psychiatric care then beds should be available in the same way that general community psychiatric beds are available to a community member with a similar presentation.

Equivalence also means having equivalence in programs to eliminate seclusion and restraint that might otherwise be used to manage behaviours associated with a person's mental illness. A person in prison with a mental illness should be no more likely to be secluded or restrained because of behaviours associated with their mental illness, than they would be if admitted to a best practice community hospital. This requires having alternative strategies for managing risk, and rigorously analysing every episode of restraint. Maximum periods of review need to be set for both restraint, and seclusion in solitary confinement cells.

This can all be quantified. Somewhere in Canberra a National Mental Health Service Planning Framework has been developed – a framework that has been recently launched but not been released. I am expecting it will give targets of numbers of workers in the community and numbers of beds, which will show the gaps that we have for the general population. A similar planning framework can be used to set targets for service levels for prison populations..

So in South Australia for example, the Government is estimating that we will have 2,270 prisoners this year in total. Butler's (2005) NSW study reported that 43% of prisoners have a diagnosis of psychosis, anxiety disorders or mood disorders – 61% of women prisoners and 39% for men. So on the back of the envelope we could plan to provide prevention services to all 2,270 people in prison and then deliver mental health care to 80 women in prison who will have a mental illness, and 835 men who have an illness

Even allowing for the mental health work already done by Corrections staff and prison health services, a standard size mental health team is likely to be needed to provide this in reach, and support front line corrections and primary care staff.

In South Australia we have considerable gaps in service provision. The SA Government in 2007 noted that our forensic inpatient facility, James Nash House, is now outdated and the facilities are not in line with modern treatment principles. There is limited access for prisoners to beds in James Nash House beds. Only 1-3 beds are available at any time. More mental health inreach is needed into prisons.

In March 2011 using Commonwealth funds, the SA Government has announced the development of 10 step down beds for forensic patients and in July 2012 it announced the funding of an extra 10 acute beds, increasing the number from 40 to 50. Both initiatives are positive and welcomed, but the need for acute beds for both forensic patients and prisoners is so great, we estimated some years ago that at least 60 beds would be needed.

We have considered other National Forensic Mental Health Principles in our 2012 Annual Report. We did not consider that the SA system provides equivalence with the non-offender. We doubt that any system in Australia would. The remaining principles are either not met or partially met. For example the principle related to the provision of safe and secure treatment is not met. We based this on the observation that prisoners who should be transferred to a forensic bed can instead be kept in prison in a non-mental health setting because of the lack of such beds. Furthermore solitary confinement in prison can be used as an intensive care psychiatry ward.

It is probably not necessary for me to say this, but this is not a criticism of individuals. This is a system issue. We have skilled, dedicated practitioners, doing good work in the face of significant service capacity limitations in all the areas of forensic practice.

### Convention Against Torture and other Cruel Inhuman and Degrading Treatment and Punishment

Juan Mendez, in his Special Rapporteur's March report, discussed torture, and other cruel, inhuman and degrading treatment in health care (Mendez, 2013). When I read his report it shocked me, because it said that torture occurs in hospitals. Previously I would have described the application of physical restraint that could have been otherwise avoided as abuse; particularly when it is repeated and prolonged. Is it torture?

Mendez considers the definition of torture from the convention:

*torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person*

*information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.*

Significant elements of the definition are: Torture can inflict pain, but it can also include the infliction of mental suffering. Physical or mechanical restraint might cause both pain and suffering, but mental suffering is more common. We know that people who have been restrained can experience significant psychological trauma. The definition of torture is not confined to the infliction physical pain.

Torture is not just about interrogation. It is not only the Guantanamo Bay scenario that we might commonly think of. It includes the infliction of punishment

The European Court of Human Rights has concluded that torture can occur when there is either an explicit or implicit aim of inflicting punishment.

Clinical Restraint, we know, is not about punishment. If a patient is restrained and you ask staff why, the reason will be to keep the patient safe, to keep other people safe, to deliver treatment.

Yet if you were to be a fly on the wall, if you did not hear the stated reasons, and were to just look down at a situation unfolding what might you think? If you were to watch a young person with a mental illness and a brain injury be restrained, then set free, become agitated, and be restrained again. A situation that is avoidable, if a bed on a unit is available. If you did not hear the stated reasons, but only saw the events, what would be the reason for the restraint? Could this be punishment? Problem behaviour; shackled; Problem behaviour again; shackled.

Once again this is not a criticism of dedicated staff, staff who are also at risk. Noone is wanting to call hard working dedicated staff torturers.

The significance is that any action defined as torture is prohibited.

From the convention

*each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.*

If it is torture it cannot happen – it is banned, it is prohibited. It has to stop. If we think of it as inhuman or degrading we can debate whether it is or not, and what our actions should be. Torture though has an absolute prohibition.

I am not promoting Mendez's comments from a moral high ground. Our Office is both part of the the solution, but also responsible for our part of the problem. We act as an advocate for mental health patients and prisoners with a mental illness or disability who are restrained. But, as guardian of last resort we also seek guardianship orders to authorise the restraint of people with a disability. For example people who have no disability accommodation to go to,

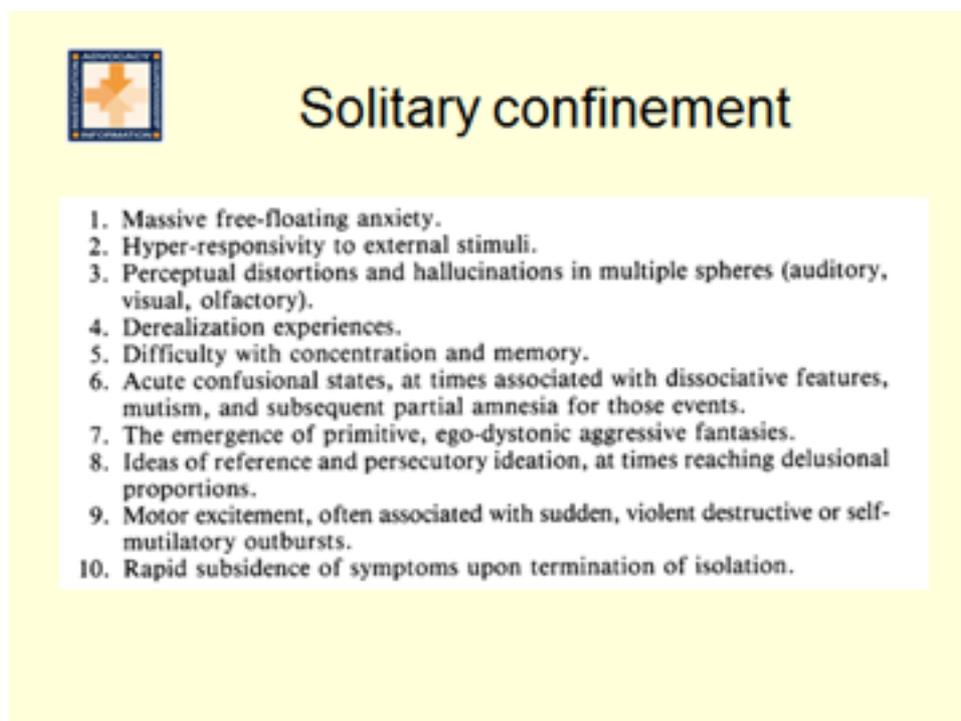
may be held in a general hospital waiting, and be subject to multiple restraints. We all share responsibility for this problem, and need to address it.

### Solitary confinement

This is a related topic . Solitary confinement can inflict mental suffering, and be used for punishment.

It is worth reviewing the evidence. Reports of the psychological harm of solitary confinement goes back one hundred years. German clinicians wrote up thousands of descriptions of psychosis associated with solitary confinement, and now more recent literature has demonstrating serious psychopathological consequences.

Grassian and Freedman, in 1986, synthesized the literature on solitary confinement, describing a distinct syndrome of features related to sensory deprivation. This is a list from their paper.



The slide features a yellow background. In the top left corner, there is a small square icon with a blue border and a white cross. To the right of the icon, the title "Solitary confinement" is written in a large, bold, black font. Below the title, a white rectangular box contains a numbered list of 10 items, each describing a symptom of solitary confinement.

1. Massive free-floating anxiety.
2. Hyper-responsivity to external stimuli.
3. Perceptual distortions and hallucinations in multiple spheres (auditory, visual, olfactory).
4. Derealization experiences.
5. Difficulty with concentration and memory.
6. Acute confusional states, at times associated with dissociative features, mutism, and subsequent partial amnesia for those events.
7. The emergence of primitive, ego-dystonic aggressive fantasies.
8. Ideas of reference and persecutory ideation, at times reaching delusional proportions.
9. Motor excitement, often associated with sudden, violent destructive or self-mutilatory outbursts.
10. Rapid subsidence of symptoms upon termination of isolation.

Ganser syndrome, hysterical disorder, has been linked by some authors almost exclusively to solitary confinement.

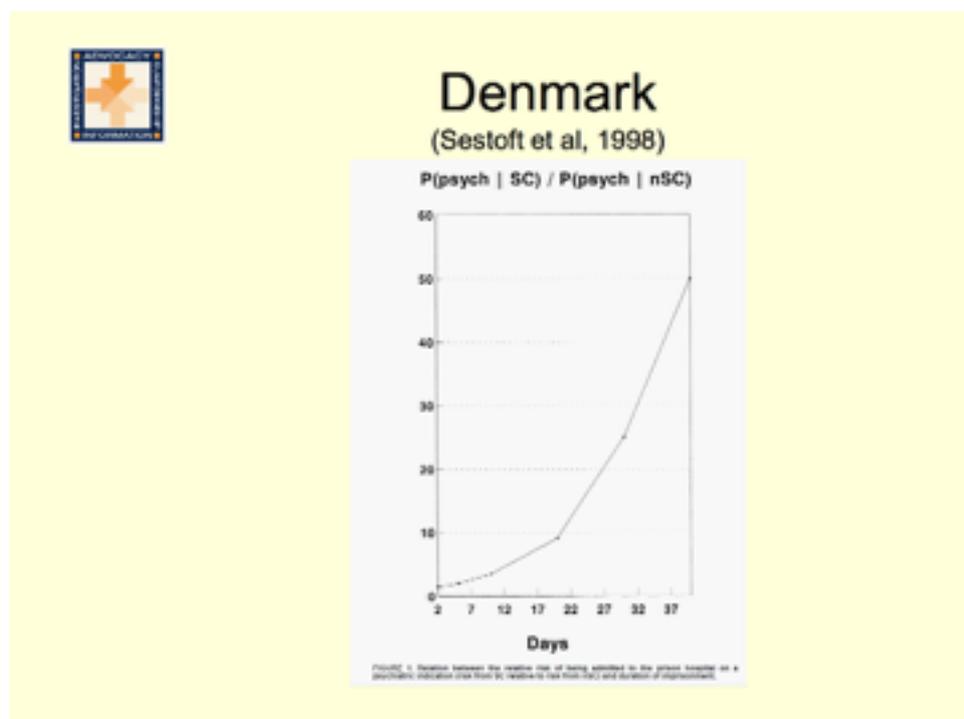
People with poor adjustment, lack of insight and insecurity in relationships were more at risk.

To me when thinking of our advocacy and guardianship clients who have been placed in solitary this rings true. The dissociation, the partial amnesia, the anxiety that can develop if a return to solitary is required, and also the rapid improvement when people are transferred out of this setting can be seen.

Nevertheless there is still some debate about whether or not solitary confinement causes harm, and I wish to cite two studies, one from 1998 and one from this year.

One Danish study (Sestoft et al, 1998) compared the risk of prisoners admitted to a prison hospital from either solitary confinement or non-solitary confinement. These were remand prisoners placed in solitary confinement due to a risk of collusion. (In comparison we meet remand prisoners in solitary, but for our clients this is because of behavioural problems related to a mental illness, brain injury or personality disorder, that would be addressed without solitary confinement in a clinical setting.)

From this detailed examination solitary confinement prisoners were more likely to be admitted to the prison hospital for a psychiatric cause than non-solitary confinement prisoners, and this was due to depression, adjustment disorder and mixed somatic/psychiatric causes, not psychosis.



The relative risk of admission can be seen in this slide of a graph from this paper. The risk of being admitted to the prison hospital at the start of imprisonment is the same for people in solitary confinement and not in solitary confinement, However with time in solitary the relative risk of being admitted for a psychiatric reasons increased remarkably - about 20 times as high for a person remanded in non-solitary confinement for the same period of time.

The evidence however is not all consistent. This year a study from Colorado was published comparing male prisoners in 23 hour a day administrative segregation, with those in the general prison population, and those placed in a special needs prison for prisoners with a mental illness (O'Keefe et al, 2013).

Longitudinally over a year prisoners were assessed using the the Brief Symptom Inventory, a 53 item self report measure. Prisoners were paid \$10 per assessment for each of the 6 assessments.

There was no evidence of decline. In fact there was an initial improvement in all the prison groups that was maintained. The limitations of this study included its limitation to literate male offenders, who were behaviourally disruptive inmates, who may have had a past experience of segregation and segregation varies from state to state. The authors said they were surprised that psychological effects did not appear in their data from their experience of seeing individuals in psychological crisis in segregation.

It is reasonable to expect that prisoners with a mental illness will be particularly vulnerable to the effects of solitary confinement. The former Special Rapporteur on Torture, Manfred Nowak in 2008 recommended that solitary confinement should be absolutely prohibited for mentally ill prisoners.

Juan Mendez has called for prolonged solitary confinement to be subject to an absolute prohibition, and that there be an explicit prohibition on the use of solitary confinement of persons with psychosocial disabilities (Mendez, 2013b).

It is not our Office's role to comment on the more general use of solitary confinement in Corrections, however the UN recommendation of absolute prohibition of solitary for the use of mentally ill prisoners cannot be ignored.



## Conclusion

- **Population based mental health services: equivalence of care**
- **Restraint and seclusion to be minimised and prevented.**
- **Adequate mental health services can prevent the need for restraint, seclusion and solitary confinement**
- **The use of solitary confinement for mentally ill prisoners should be prohibited.**

*Notes on this version: Some sections of this presentation were originally prepared in note form, and was presented from these notes. Text for these sections was written subsequently.*

## References

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