Providing treatment to prisoners with mental disorders: development of a policy†

Selective literature review and expert consultation exercise

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Background Mental disorder is more prevalent among people in prison than in the general population. Prisoners who require transfer to psychiatric hospitals for treatment face long delays. Doctors working in prisons regularly face ethical and legal dilemmas posed by prisoners with mental illness.

Aims To develop a policy for providing treatment under the common law to prisoners with mental disorders who lack treatment decision-making capacity, while arrangements are made to transfer them to hospital.

Method The policy was developed through literature review and consultation with the Faculty of Law at Southampton University and health care staff at Winchester prison in the UK.

Results The policy provides guidelines for establishing decision-making capacity, standards for documentation, and guidelines for implementation based on the Mental Health Act Code of Practice, other best-practice guidelines and case law.

Conclusions It can be argued that case law allows more-extensive treatment to be provided in the best interests of the incompetent prisoner, beyond emergency situations. The policy has ethical implications and its use should be carefully monitored.

Declaration of interest None.

†See editorial, pp. 287–288, this issue.

The report *The Future Organisation of Prison Health Care*, jointly published by HM Prison Service and the NHS Executive (1999), promised better health care for prisoners delivered through a new partnership created between these two organisations. Central to the reform of prison health care is the simple but radical concept that health care in prisons should be based on the principle of equivalence. The Prison Service has aimed to provide prisoners with health care of the same standard as the National Health Service (NHS) since 1990 (Home Office, 1990), and the principle of equivalence was central to the discussion paper entitled *Patient or Prisoner?* (Her Majesty's Inspectorate of Prisons, 1996). The year following the publication of this paper, the Health Advisory Committee for the Prison Service (1997) helpfully teased out what equivalence meant in practice in relation to mental health care: namely, that prisoners should be entitled to expect the same standard of health care as that provided in the community, and have similar access to NHS beds. Although this is based on sound ethical principles, in practice it is difficult to achieve.

THE SCOPE OF THE PROBLEM

Psychiatric morbidity is prevalent among prisoners (Office for National Statistics, 1998). Because conditions in prison are not conducive to good mental health, prisoners with mental illness are at risk of experiencing a deterioration in their mental state. Evidence also suggests that outcomes for people with schizophrenia are worse when they are not subject to ongoing treatment (Wyatt, 1991).

No part of a prison is recognised as a hospital under the Mental Health Act 1983. Because there is no statutory provision for the treatment of people with mental disorders in prison, circumstances in which treatment can be enforced are limited. Without consent, treatment can be given only in emergencies or where the common-law justification of necessity permits medical or other interventions to an extent that might be considered reasonable under the circumstances. If a patient or prisoner lacks capacity, treatment may be justified in their best interests, as defined in *Bolam v. Friern Hospital Management Committee* (1957), modified by *Bolitho v. City and Hackney Health Authority* (1997). The latter is based upon assessment of clinical need rather than risk of serious harm. This means that prisoners with mental illness that requires urgent treatment, including treatment in the absence of consent, need to be transferred promptly to NHS treatment facilities. Sections 47 and 48 of the Mental Health Act 1983 provide a legal framework for this. In reality many prisoners with mental disorders wait for long periods for a suitable bed, or are not accepted by services (Reed & Lyne, 1997, 2000). For those who remain in prison the situation is exacerbated by the fact that the Care Programme Approach is not widely implemented in prisons, and standards of health care are inferior to those provided outside prison (Smith, 1999). This means that until adequate resources are provided by the NHS, enabling those with serious mental illness to be quickly transferred to hospital, prison doctors and visiting psychiatrists will continue to be confronted by considerable ethical and legal dilemmas posed by prisoners with serious mental illness, on a frequent and regular basis.

In order to address these issues and to tackle the other health care needs of mentally disordered offenders outlined in the report by the joint working party of the Home Office and Department of Health (HM Prison Service & NHS Executive, 1999), we have been working with the prison health care team at Her Majesty's Prison Winchester to develop mental health care for prisoners held there. One aspect of this has involved consultation with the Law Faculty at the University of Southampton and examination of the relevant case law to produce a policy for use in providing treatment under the common law to prisoners with mental disorders who lack treatment decision-making capacity, while arrangements are made to transfer them to hospital. In this paper we present the policy and discuss implications for its use.

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THE POLICY

This policy covers the criteria for establishing the presence or absence of treatment decision-making capacity, standards for documentation, and guidelines for implementation.

Guidelines for establishing capacity

Where there is a necessity to act in the best interests of a patient who is thought to lack capacity, an assessment of capacity is made by the prison medical officer according to the Mental Health Act Code of Practice (Department of Health & Welsh Office, 1999) criteria based on *Re C* (1994) and supported by the Law Commission (1995). This should be done in consultation with the prison multi-disciplinary team, in accordance with best practice for the care of prisoners with mental disorders. Where practicable a second opinion from a visiting NHS psychiatrist should also be obtained. According to *Re C*, to have capacity a person must be able to:

(a) understand in broad terms the treatment proposed and that the health professional thinks it is necessary;

(b) retain the information;

(c) understand in broad terms the benefits and risks of the treatment and the consequences of not having it;

(d) believe the relevant information;

(e) weigh it in the balance so as to arrive at a choice.

Competent adults have an unassailable right to refuse all treatment under common law, even if this will result in their death (*Re AK*, 2001). Someone with a mental disorder may make a treatment decision that seems irrational to the clinical team, but this does not necessarily equate with incapacity (*Re MB*, 1997). A specific diagnosis of mental disorder is not required to make a finding of incapacity – there must simply be some 'impairment or disturbance of mental functioning, which may be temporary or permanent' (*Re JT*, 1998).

Real consent in prisons is contentious owing to the coercive nature of the institutions. In *Freeman v. Home Office* (1984) the effect of a coercive institution upon consent issues was considered, with the conclusion that the presence or absence of real consent was a question of fact to be considered on a case-by-case basis.

Guidelines for documentation

The prison inmate should be informed of the purpose of the assessment, and the findings documented in the Inmate Medical Record (IMR). As a minimum, the entry in the IMR should include:

(a) mental state examination

(b) information given to patient (including choices or alternatives)

(c) explanation of consequences of not having proposed treatment

(d) discussion within multi-disciplinary team

(e) statement of patient's capacity or incapacity

(f) specified treatment plan

(g) time frame for review.

Guidelines for implementation

It is the practitioner responsible for the care of the inmate who must decide the issue of competence. This should be guided by discussion with other health professionals and where practicable a second opinion from a visiting psychiatrist. Although the law does not require the standard of treatment given in prison to match that provided by specialist psychiatric services (*Knight v. Home Office*, 1990), this policy contains the following guidelines to ensure that the best standard of treatment is given when transfer to hospital under the Mental Health Act 1983 is not expedient:

(a) ongoing assessment with a view to transfer to NHS hospital should be organised without delay;

(b) a second opinion from a psychiatrist approved under section 12(2) of the Mental Health Act should be obtained in cases of doubtful or fluctuating capacity;

(c) the next of kin should be consulted where practicable (as per Mental Health Act Code of Practice guidelines);

(d) a standard psychotropic formulary should be developed for use in the prison;

(e) treatment plans should broadly follow the Maudsley Hospital Prescribing Guidelines (Taylor *et al*, 2001);

(f) rapid tranquillisation is to be given in accordance with the Royal College of Psychiatrists' guidelines (Royal College of Psychiatrists, 1998);

(g) rapid tranquillisation is to be administered only where appropriate resuscitation equipment is available;

(h) there should be integration with prison policies on seclusion and restraint;

(i) staff training is required.

DISCUSSION

Interpretation of the legislation

In the absence of guidelines such as those described in this policy, the practice of health professionals working in prisons is liable to be influenced to a significant degree by their own knowledge and interpretation of the law relating to the treatment of individuals who are temporarily or permanently incompetent. We suggest that the case law provides guidance for the provision of more-extensive treatment plans (which may include a course of treatment) in the best interests of the incompetent prisoner beyond emergency situations where there is an immediate danger to the patient or others. In developing this policy our aim is to provide a consistent approach with appropriate safeguards, which goes some way to filling the legislative gap that currently exists.

Integration with Human Rights law

Any policy of this nature will need to be compatible with the Human Rights Act 1998. Prisons are included in those public establishments required to abide by this legislation. Article 2 states that 'everyone's right to life shall be protected by law'. It may be argued that, for those with serious mental disorder, this equates to a right to receive treatment for their illness, whether they are consenting or not (*Keenan v. UK*, 1998). Article 3 states that 'no one shall be subjected to torture or inhuman or degrading treatment or punishment'. *Herczegfalvy v. Austria* (1992) states, 'A measure which is a therapeutic necessity cannot be regarded as inhuman or degrading.' Side-effects of intramuscular depot antipsychotic medication were claimed to be inhuman and degrading; however, these claims have not been upheld (*Grare v. France*, 1992). Nevertheless, the use of depot antipsychotic preparations under the common law is contentious. A patient might regain capacity but remain subject to the therapeutic and adverse effects of the drug for a considerable time even though he or she might be competently refusing consent. This is not dissimilar to

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emergency treatments undertaken in surgery, where effects from the intervention last well in excess of the period during which the patient lacks competence. It may be argued that for those with a history of persistent or relapsing psychotic conditions who are not neuroleptic-naïve, treatment with depot antipsychotic medication represents treatment in the best interests of the patient.

Potential shortfalls and ethical implications

The standard of health care provided in prison has been a source of concern for many years (Smith, 1984). Careful consideration must be given to the impact of implementing any policy that extends treatment provision within a prison setting where health care inadequacies exist. For example, the policy that led to the development of surgical units at Liverpool and Parkhurst prisons during the 1980s failed because these units never functioned effectively and they proved very costly to run (Home Office, 1990). These two units were eventually shut down and a third, planned for Wormwood Scrubs, never became operational.

There are undoubtedly inadequacies in mental health care provision in prisons. A study of the in-patient care of people with mental illness in prison based on the inspection of 13 prisons with in-patient beds in England and Wales revealed that no doctor in charge of in-patients had completed specialist psychiatric training, suitably trained nursing staff were in short supply, patients' lives were unacceptably restricted and the availability of therapy was limited (Reed & Lyne, 2000). It is also recognised that there are unacceptable delays in arranging the transfer of prisoners with mental illness to the NHS, and in some cases the NHS does not give such patients the same priority as they would have if they were admitted from the community (Department of Health & Prison Service, 2001).

It must be stressed that this policy is adjunctive to the process of seeking a hospital bed; it is not intended to provide an alternative to organising immediate assessment under the Mental Health Act. This policy also seeks to provide a consistent set of standards for the treatment of people with mental illness in prison awaiting transfer, based on best-practice guidelines. It could be argued that provision of some treatment within prison might adversely affect prisoners' chances of transfer to a hospital facility, because if they have shown partial response the perceived need for rapid transfer might decline and scarce resources might be prioritised elsewhere. However, against this, the ethical issues associated with leaving untreated a prisoner with a serious mental illness, and the longer-term implications of that person remaining in prison, must be taken into consideration. In our view the clinical needs of the patient will often outweigh other considerations, and we argue that prisoners with mental disorders should receive ongoing treatment for their disorder more frequently than occurs at present.

Resource implications and outcome measures

In order to meet the guidelines for implementation, we propose that this policy is suitable for use only in prisons with established health care centres supported by regular input from NHS psychiatrists. The standard of care expected would be that of a primary care or community mental health team initiating treatment in the community. This precludes treatment that should be initiated on an in-patient basis, such as pharmacotherapy with high-dose antipsychotic medication or clozapine. It must also be integrated with existing prison policies. The implementation of this policy has clear implications for the training of prison staff. The use of the policy requires careful monitoring and it should be subject to regular audit. We recommend that the outcomes for all patients who undergo treatment according to this policy be assessed by such measures as clinical response, adverse events, result of the Mental Health Act assessment process, and whether the patient was transferred to NHS facilities.

CLINICAL IMPLICATIONS

- Existing case law can be used to support a policy of providing more-extensive treatment under common law for prisoners with mental disorders provided that they lack capacity and treatment is in their best interests.
- A policy of this nature should not be used as an alternative to organising immediate assessment under the Mental Health Act 1983 and seeking transfer to hospital without delay.
- The policy has implications for the training of prison staff.

LIMITATIONS

- There is no existing legislative framework for providing treatment of mental disorders to people in prison.
- This policy has not yet been formally evaluated in practice.
- In view of its potential shortfalls and the ethical implications of implementing this policy, we recommend that it should be used only in established prison health care centres where there is regular input from National Health Service psychiatrists.

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