

## Ethical issues — equivalent care and consent

### **Key ethical principles**

The healthcare of prisoners requires a sound ethical framework. The key principles are the following.

- The quality of care provided should not be dependent upon fluctuating social and political attitudes towards crime and punishment.
- Loss of liberty must not entail the loss of a right to medical treatment to a proper ethical and clinical standard. Care of an equivalent standard to that available outside prison should be provided (concept of equivalence of care).
- The concept of equivalence of care rests in turn upon the principle that imprisonment should be used 'as a punishment, not for punishment'.

### Equivalent care

Achieving equivalent care for prisoners requires sustained effort and significant cooperation of healthcare professionals working in the community, those working in prison, other prison staff, Primary Care Trusts and Health Authorities, and central government officials. It is generally recognised that the aim of providing equivalent care is not yet achieved, with particularly disturbing problems in some areas with services for prisoners with mental-health problems and with the recruitment and retention of properly trained healthcare staff. In the interim period, clinicians will need to apply ethical guidelines for professional practice in clinical settings falling short of what is expected of a comprehensive psychiatric service.

To work effectively in prisons, healthcare professionals need to consider the needs of a prison and of the wider organisation. The potential tension between 'care' and 'control' is by no means exclusive to forensic settings; however, it is brought into sharper focus there and potential conflicts of interest are to be expected. Professionals need to deal with these as part of their everyday work, but when doing so they must be careful not to allow their ethical standards to be compromised.

Healthcare staff working in prison have a particular responsibility to act as advocates for adequate healthcare for mentally disordered prisoners by drawing the attention of the prison governor and the local Primary Care Trust/Local Health Group to the need to improve services, where there is a need to do so. The situation where healthcare staff have clear evidence that deficiencies in the service put their patients at unacceptable risk is dealt with below.

There is also an ethical obligation on psychiatric services outside the prison to respond promptly to requests for urgent assessment.

### Consent to treatment

#### Requirement to obtain consent

Generally, health professionals cannot legally examine or treat any adult who has not specifically agreed to the examination or treatment. Treatment in this context includes the administration of food or liquids. Consent must be voluntary and must not be obtained by use of unfair pressure. If it is, the consent is invalid. Healthcare interventions carried out without valid consent, even if they are intended to be of benefit, may constitute an assault. Consent is required on every occasion an examination or treatment is offered, except in some emergencies or where the law prescribes otherwise. Consent can be verbal, written or implied by acquiescence. Acquiescence, when a patient does not know what the intervention entails or that there is an option of declining, is not valid consent.

Not everyone may be able to provide valid consent. Conditions that may interfere with the giving of valid consent include intellectual disability, organic brain dysfunction, the effects of drugs, the level of consciousness, mental illness and tiredness. Therefore, before consent is sought, the person must be judged capable of giving it. This is known as 'capacity' or 'competence' to consent to treatment.

Adults who have capacity are entitled to refuse consent to health interventions (other than treatment for mental disorder under the Mental Health Act 1983) even when doing so may result in permanent injury or death provided they fully understand the consequences of their decision.

#### Does the patient have capacity?

In the UK, an adult (aged 18 or over) is presumed to have capacity to consent to or refuse treatment until proved otherwise.

In determining whether the presumption of capacity can be rebutted in any individual case, the law requires doctors to examine whether the person concerned can follow the decision-making process of 'first, comprehending and retaining the treatment information, second, believing it (which does not necessarily mean accepting it) and third weighing it in the balance to arrive at a choice'.

Thus, to have capacity, the patient must be able to:

- understand what in broad terms is the nature of the treatment and that somebody has said that he/she needs it and why the treatment is being proposed
- understand its principal benefits, risks and alternatives
- understand what will be the consequences of not receiving the proposed treatment and
- retain the information for long enough to make an effective decision.

In determining any individual case, consideration should be given to the nature of the decision to be made. There may be reduced capacity and what matters is whether at that time the person's capacity was reduced below the level needed to make a decision of that particular importance. Mental illness, learning disability or imprudence do not on their own indicate a lack of capacity.

The capacity to give or refuse consent may come and go over time. It needs to be kept under review. Healthcare staff should record in their notes patients' views about consent or refusal of treatment. Consent once given is not final and can be withdrawn at any time, ie a person can change his/her mind.

Capacity in young people (those under 18)

- **A patient who is under 16 is not presumed to be competent to give consent.** They must demonstrate this. The central test is whether the young person has sufficient understanding and intelligence to understand fully the nature, purpose and possible consequences of the proposed intervention.
- **Where a patient under 16 is competent, he/she can give consent to an examination or treatment.** It is not then necessary to seek consent from those with parental responsibility (ie parents or the Local Authority). Prison staff are not considered to be *in loco parentis*. It is good practice to involve parents, particularly for important or life-changing decisions, unless the young person requests that the matter remains confidential.
- **However, in England, Wales and Northern Ireland, even where a patient under 18 is competent, he/she may not necessarily refuse treatment if those with parental responsibility or a court allow the treatment to be given.** Where a competent young person refuses treatment, the harm caused by violating the choice must be balanced against the harm caused by failure to treat. If the disagreement is about a serious matter, it will often be better for a court to become involved rather than allowing parents automatically to overrule the young person. In Scotland, it is unlikely that the refusal of treatment by a competent young person can be overridden by parents or the courts.
- **Where a patient under 18 lacks capacity, someone with parental responsibility (ie a parent or Local Authority) can consent to treatment on their behalf.** The Children Act 1989 sets out persons who may have parental responsibility. They include the child's parents if married to each other at the time of conception or birth, the child's mother if not so married, the child's legally appointed guardian, a Local Authority designated in a care order in respect of the child, and a Local Authority who holds an emergency protection order in respect of the child. A full list is set out in Section 2(9) of the Children Act 1989 and in the Department of Health *Reference Guide to Consent for Examination or Treatment*. Where there is any doubt about who has parental responsibility, a specific enquiry should be made.

Has the patient received sufficient information?

To give valid consent, the patient needs to understand in broad terms the nature and purpose of the procedure. When seeking consent, the healthcare worker must give the person an account in simple terms of the benefits and risks of the proposed treatment and explain the principal alternatives to it in a manner the patient can understand.

How the information is presented is important. Information should be presented in the following ways.

- In the patient's own language. This is essential where the decision is one of life and death, eg where an Immigration Act 1971 detainee is refusing food. An interpreter may be required.
- In simple and clear language and, if necessary, broken down into chunks to aid understanding.
- In a form that takes account of any disability or impairment of the patient (eg deafness or blindness).
- Where possible, both verbally and in written form.
- At sufficient length for the patient to be able to understand it.
- On several occasions, especially where the decision is ongoing, eg food refusal.

Is the consent given voluntarily?

To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the patient. In environments (such as prisons and mental hospitals) where there is a potential for treatment offers to be perceived coercively, extra care should be taken to ensure that the patient makes a decision freely. Pointing out the potential benefits of treatment for the patient's health does not constitute coercion, but threats such as withdrawal of any privileges or loss of remission of sentence for refusing consent does. Coercion invalidates consent.

Advance statements (known as 'living wills' or 'advance healthcare directives')

People who understand the implications of their choices can state in advance how they wish to be treated at such a time as they suffer loss of capacity. Such advance statements may either request a particular form of treatment or refuse particular forms of treatment. Where this statement refers to a refusal, it is sometimes known as an advance directive. For example, a patient who is refusing food may give a clear instruction refusing some or all medical procedures should their physical state deteriorate to such an extent that they lack capacity (an advance directive). An advance statement can be written, or it can be a witnessed oral statement or the note of a discussion recorded in the patient's file.

Advance requests for treatment are not legally binding, but advance refusals of treatment are, providing that the patient is an adult (over 18), had capacity and was properly informed when reaching the decision, the statement is clearly applicable to the present circumstances and there is no reason to believe that the patient has changed his/her mind. If doubt exists about what the patient intended, the law supports a presumption in favour of providing clinically appropriate treatment. Any advance statement is superseded by a clear and competent contemporaneous decision by the patient concerned. Where the patient is under 18, advance statements should be taken into account but do not necessarily have the same status as those of adults (see **Does the patient have capacity?** above).

Treatment without consent

Where a patient is suffering from a mental disorder which is leading to behaviour that is an immediate serious danger to self or to others, compulsory treatment is possible under the Mental Health Act 1983 but only in an NHS psychiatric hospital or appropriately registered mental nursing home to which he/she should be immediately transferred (see **Use of the Mental Health Act 1983**, page 149).

Patients in prisons cannot be treated without consent, except in certain very limited circumstances (for information, see **Emergency treatment under common law**, page 168).

Professional guidance on consent

Please note: this section does not provide comprehensive guidance on all issues surrounding consent. Further guidance can be found in:

- British Medical Association. *Report of the Consent Working Party: Incorporating Consent Toolkit*. London, 2001.
- General Medical Council. *Seeking Patients' Consent: The Ethical Considerations*. London, 1998.
- Department of Health. *Reference Guide to Consent for Examination or Treatment*. London, 2001.
- British Medical Association. *Consent, Rights and Choices in Health Care for Children and Young People*. London, 2001.
- British Medical Association. *The Impact of the Human Rights Act 1998 on Medical Decision-making*. London, 2000.
- British Medical Association. *Assessment of Mental Capacity*. London, 1995.

#### **Consent to treatment: a summary**

- Health professionals cannot legally examine or treat any adult who has not specifically agreed to the examination or treatment. Treatment in this context includes the administration of food or liquids. The consent must be voluntary and must not be obtained by use of unfair pressure.
- Where a patient suffers from a mental disorder which is leading to behaviour that is an immediate serious danger to self or to others, compulsory treatment is possible under the Mental Health Act 1983, but only in an NHS psychiatric hospital or in an appropriately registered mental nursing home to which he/she should be immediately transferred.
- It may be possible to treat a patient under common law if they do not have the 'capacity' to give valid agreement to treatment. It is also required that the treatment is 'in their best interests' and that it is in accordance with a practice accepted at the time by a reasonable body of medical opinion skilled in the particular form of treatment in question.
- To have capacity, the patient must be able to:
  - understand what in broad terms is the nature of the treatment and that somebody has said that he/she needs it and why the treatment is being proposed

- understand its principal benefits, risks and alternatives
- understand what will be the consequences of not receiving the proposed treatment and
- retain the information for long enough to make an effective decision.
- Advance refusals of treatment are legally binding providing that the patient is an adult (over 18), had capacity and was properly informed when reaching the decision, the statement is clearly applicable to the present circumstances and there is no reason to believe that the patient has changed his/her mind.
- Where a patient lacks the capacity to consent to or refuse treatment and there is no valid advance statement, the doctor has a duty of care under common law to provide treatment that is in their best interests.

## Confidentiality

### Importance of confidentiality

Maintaining confidentiality of health information is one of the keystones of the patient–clinician relationship. Patients must be able to trust their healthcare workers not to reveal information inappropriately about their particular conditions or their behaviours (such as a relapse into drug misuse). Some particular groups of inmates (eg asylum-seekers detained under the Immigration Act 1971) may require considerable reassurance before they can trust healthcare staff. Maintaining confidentiality is particularly difficult in a prison. Prisons are closed societies and non-healthcare staff and inmates alike may surmise something about a patient’s health simply by observing which professional a prisoner is going to see or which drug he/she is taking. Consequently, healthcare workers need to take extra care to safeguard patient confidentiality and to be seen by their patients to do so.

### Importance of sharing information

On the other hand, there are occasions when it is in the best interest of the patient, or it is essential for the safety of others, that information is shared with others. These occasions include the following.

- Giving information and advice to non-healthcare staff (wing manager, personal officers, teachers, workshop supervisors) about the best way to manage and support a particular patient on ordinary location. It will frequently be appropriate for healthcare staff to act as advocates, eg to promote family contact, extra visits or telephone calls, to influence an appropriate location, to support suitable work placements or to acquire appropriate reading or art materials. In some ways, this is analogous to giving information to relatives and carers in the community.
- Participating in the multidisciplinary processes set up to plan the patient’s sentence and then resettlement care in prison and back to the community. In some ways, this is analogous to participating in multidisciplinary Care Programme Approach (CPA) meetings in the community. It is essential to share information outside healthcare to facilitate creative solutions such as moves between wings and the healthcare centre, ‘respite’ stays in the healthcare centre, a mixed location (eg education centre or sheltered work during the day, the healthcare centre at night) and a planned response to a crisis, eg in the case of chronic self-injury in the presence of personality disorder, where several disciplines may be involved.
- Participating in procedures to support the multidisciplinary care of patients thought to be at risk of suicide or self-harm (currently in England and Wales F2052SH, in Scotland the Act to Care). Healthcare staff must provide clear guidance to other staff about the most effective ways of managing risk factors and what signs or symptoms should trigger a request for a further healthcare intervention.
- When the healthcare worker becomes aware that the patient presents a risk of serious harm to some other individual or group of individuals.
- When the healthcare worker becomes aware that a child is at risk of serious harm, including abuse (see **Child protection**, page 276).

### Ways of sharing information while maintaining confidentiality

There are several ways to maximise the sharing of information required for multidisciplinary care while maintaining the requirements of confidentiality and the trust of the patient. These include the following.

- **Agreements allowing confidentiality to be held within a designated team.** This is what occurs within general practice teams and within multi-agency mental-health teams (usually consisting of doctors, nurses, social workers, occupational therapists, psychologists and non-professional ‘support workers’). Patients are informed at the assessment stage that information about them may be shared on a need-to-know basis with the team and that confidentiality is maintained

within the team boundary. Your local 'Caldicott Guardian' may be able to help you draw up a suitable protocol. (All Health Authorities and Primary Care Trusts/Local Health Groups have a Caldicott Guardian — a senior clinician on the Board — who is responsible for agreeing and reviewing protocols governing the disclosure of patient information across organisational boundaries).

- **Asking the patient for permission to share certain information with others.** Emphasise that the purpose is to ensure that the patient is treated as well as possible on ordinary location and receives appropriate aftercare when he/she is released. Where this is explained sympathetically, many prisoners will agree to appropriate levels of disclosure. Permission is required on every occasion you are planning to disclose significant information. Permission should be written if possible. A copy of a template confidentiality agreement with a patient can be found on the disk .
- **Giving general information about how to treat a group of prisoners.** It is often possible to give residential managers and workshop managers general information about how to manage prisoners with particular problems (eg those who are withdrawn, who hear voices, who have paranoid delusions) without giving confidential details which are on the inmate medical record (IMR) of a particular individual.
- **Providing the prisoner with the opportunity to talk directly with other staff.** The prisoner may be willing to disclose the relevant information to another member of staff (eg counselling, assessment, referral, advice and throughcare services [CARATS] worker, probation officer) themselves. Gaining patient permission to share information may be easier if the patient sees the report that is being shared or is present at the discussion about them.

When confidentiality may be overridden

Where there is a grave risk of serious harm to the individual or to others and the individual refuses consent to disclose information to avert such harm, the duty of confidentiality can be overridden by the duty in the public interest to prevent serious harm. In this case, information relevant to managing that risk should be shared on a need-to-know basis. Unless doing so risks serious harm, the patient should be informed about who has been told what and why.

What constitutes 'serious harm' is not defined in law and may be difficult to judge. Consultation with appropriate colleagues is advised and staff may find the guidance given to assist prison and probation staff assess the risk of serious harm helpful: 'a risk which is life-threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.

Professional guidance

The guidance of the most relevant professional bodies on confidentiality is summarised below.

*General Medical Council (GMC)*

The GMC in its guidance *Confidentiality: Protection and Providing Information* (2000) emphasises the importance of seeking patient consent to disclosure:

You must obtain express consent where patients may be personally affected by the disclosure... When seeking express consent you must make sure that patients are given enough information on which to base their decision, the reasons for the disclosure and the likely consequences of the disclosure. You should also explain how much information will be disclosed and to whom it will be given. If the patient withholds consent, or consent cannot be obtained, disclosures may be made only where they can be justified in the public interest, usually where disclosure is essential to protect the patient, or someone else, from risk of death or serious harm. (paragraph 14)

Where third parties are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclosure where practicable. If it is not practicable, you should disclose information promptly to an appropriate person or authority. You should generally inform the patient before disclosing the information.

The GMC has confirmed that its guidance on the disclosure of information that may assist in the prevention or detection of abuse applies both to information about third parties (eg adults who may pose a risk of harm to a child) and about children who may be the subject of abuse).<sup>1</sup>

*The Royal College of Psychiatrists*

The Royal College of Psychiatrists in *Good Psychiatric Practice: Confidentiality*. Council Report CR85 (2000) suggests that decisions about whether a breach of confidence is justifiable depends on consideration of the following factors.

- **Risks of non-disclosure:** the probability of consequences and the seriousness of consequences. In general, disclosure should only be considered where there is risk of death or serious harm, including abuse.

- Benefits of disclosure: the likelihood that disclosure will have the desired result.
- Ability to identify a potential victim.
- Risk of disclosure: there may be occasions when the potential harmful effects of disclosure outweigh potential benefits.
- Context and role in which the doctor is working.

*United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)*

The UKCC's *Guidelines for Professional Practice* (1996) contains the following advice on providing information.

Disclosure of information occurs:

- with the consent of the patient or client
- without the consent of the patient or client when the disclosure is required by law or by order of a court **and**
- without the consent of the patient or client when the disclosure is considered to be necessary in the public interest.

The public interest means the interests of an individual or groups of individuals or of society as a whole and would, for example, cover matters such as serious crime, child abuse, drug trafficking or other activities which place others at serious risk. (paragraphs 55 and 56)

### **Confidentiality: a summary**

- Maintaining the confidentiality of health information is one of the keystones of the patient–clinician relationship.
- It may be in the best interest of the patient or it is essential for the safety of others that information is shared with others in order to:
  - give advice to residential staff about how best to care for a patient on ordinary location
  - participate in multidisciplinary care planning, eg sentence planning, prerelease planning
  - participate in prison multidisciplinary processes to prevent suicide and self-harm, and
  - prevent serious harm to the patient, to others or to a child.
- Ways to reconcile these two imperatives include the following.
  - Forming agreements allowing confidentiality to be held within a designated team
  - Asking the patient for permission to share certain information with others
  - Giving general information to residential staff about how to care for prisoners with particular problems.
- Where there is a grave risk of serious harm to the individual or to others, and the individual refuses consent to disclose information to avert such harm, the duty of confidentiality can be overridden by the duty in the public interest to prevent the serious harm. In this case, information relevant to managing that risk should be shared on a 'need-to-know' basis. Unless doing so risks serious harm, the patient should be informed about who has been told what and why.

### Isolation and mental health

Medical officers are required to visit prisoners held in segregation units or in seclusion to ensure that their mental state does not deteriorate to unacceptable levels and to check for other health issues. The relevant Prison Service Orders, PSO 1700A and 1700B, deal respectively with the maintenance of humane conditions in segregation units and with the management of prisoners who are segregated for any reason — whether for reasons of good order or discipline, in their own interests or protection or because of dirty protests.

### Effects of isolation on mental health

There is a high risk that isolation, seclusion and segregation may damage mental health. There is no direct evidence for the precise psychological mechanisms operating in detention in isolated conditions. However, sensory deprivation experiments provide a situation that is analogous in at least some aspects. These experiments have led to dramatic and bizarre effects including anxiety, visual hallucinations and psychotic-type symptoms.<sup>2</sup> Prisoners held in solitary confinement may suffer similar symptoms, reporting loss of memory and impaired concentration.<sup>3</sup> The English Special Units Study, which looked at the treatment of some disruptive and dangerous prisoners, found that a subgroup had spent long periods in segregation and that psychotic symptoms had emerged, unbeknown to the prison staff.<sup>4</sup> Suicide and all types of psychiatric morbidity are common in prisoners held in isolation. Although the most extreme symptoms may often be associated with the most extreme environmental conditions, there is by no means a uniform effect across individuals.

Some individuals can tolerate isolation better than others. Some people who have suffered severe and repeated traumas in childhood and their youth may be especially prone to stress-response syndromes.

#### Prisoners at increased risk of spending time in isolation

Some prisoners are more likely than others to spend extended periods in isolation or segregation. These include people who are mentally ill and/or have other disorders such as emotionally unstable (borderline) personality disorder, antisocial personality disorder and narcissistic personality disorder. They may be isolated because they present a risk to themselves or others, or because they engage in other difficult or dangerous behaviour. They may be isolated while awaiting assessment or transfer to hospital though, in current practice, individuals with personality disorder but lacking evidence of severe mental illness are unlikely to be transferred to an NHS hospital. Individuals who are seen as deliberately provocative or challenging of authority are also likely to spend long periods in isolation.

Until recently, prisoners considered at risk of suicide were sometimes managed in isolation in 'strip cells'. This is now against Prison Service instructions as it was found to be unacceptable and counter-productive (as it may increase suicidal thoughts). Use of crisis suites or shared cells is preferred. Prisoners assessed as being at a current risk of suicide or with a history of self-harm may receive some degree of protection by their placement in a dormitory. Where the risk of harm to (or from) other prisoners makes this impractical, their placement in a safer (ligature-free) cell is an alternative option (see **Assessing and managing people at risk of suicide**, page 204).

#### Management of prisoners in isolation

##### *Prisoners who are mentally ill*

Individuals who are mentally ill within the meaning of the Mental Health Act 1983 and who are held in segregation or seclusion, as that is the only way they can be safely contained, should be transferred immediately (within 24 hours) to a psychiatric hospital. Immediate transfer is often difficult, given variations in the availability of secure psychiatric beds. Nevertheless, it is an important standard (for NHS services to work towards) that such individuals should be accepted by them within 24 hours. A standard of assessment and, if necessary, admission within 24 hours for emergency cases is commonly set in the community and operates in most Scottish prisons. Where paranoid features of the illness mean that the individual refuses the limited access to exercise that is available, transfer is even more urgent (see **Liaison and referral to the NHS and Emergency treatment under common law**, pages 149 and 168).

Where the prisoner has any history, or current indication, of mental illness, self-destructive behaviour or substance misuse, an opinion should be sought from a psychiatrist and the appropriateness of relocating the prisoner in the healthcare centre considered. Where any current mental disorder is identified, a treatment plan should be drawn up and implemented.

##### *Prisoners who spend frequent or extended periods in isolation*

Prisoners who are not transferred to an outside psychiatric hospital and who are at increased risk of spending frequent or extended periods in segregation or seclusion should be managed as described in **Prisoners with complex presentations and very difficult behaviours** (page 202). Frequent or extended use of segregation, especially but not exclusively transfer from the segregation unit in one prison to that in another in order to provide respite to staff, should trigger a multidisciplinary assessment and the development of appropriate multidisciplinary care plans.

Such prisoners may benefit from admission to specialist units providing humane specialist management approaches such as the 'exceptional risk units' for prisoners with severe personality disorder who are also dangerous (eg at HMP Belmarsh). In whatever environment they are managed in, it is important to bear in mind the factors that characterise a good environment for people with a history of violence and which reduce the chances of violence being repeated. These factors include the following.

- Access to open space.
- Fresh air.
- Privacy, eg, toilet, washing and shower facilities.
- Personal space, including avoidance of overcrowding.
- Control of noise.
- Natural lighting.
- Controls of ambient temperature and ventilation.

See the Royal College of Psychiatrists' *Management of Imminent Violence*.<sup>v</sup>

### *All prisoners*

Medical officers are required to assess the health of prisoners held in segregation.

**There are conditions that are required for adequate health assessments.** Examinations of a prisoner's health should be held in adequate conditions in circumstances that allow the prisoner to express him/herself freely and by a healthcare professional who is competent in assessing their mental state. An interview room is required. The prisoner's IMR should be to hand before the examination and the results of the examination entered into it.

**The appropriate level and frequency of assessment** will vary according to the time the prisoner is held in segregation upon the doctor's clinical judgement of the prisoner's state of health and the requirements of Prison Service standards.

- **Prisoners held in segregation for a few hours only pending adjudication.** In these circumstances, the assessment may only be about whether the prisoner is 'fit' for adjudication (eg they are capable of rational thought) and of their risk of suicide. It is also useful to look for signs of depression. Depression may sometimes lead to increased irritability and aggression, and have triggered the incident that led to the use of segregation.
- **Prisoners held for longer periods in segregation.** In these circumstances, a fuller Mental State Examination (MSE) should be conducted, looking in particular for signs of stress-induced psychosis or depression. The doctor's responsibility is to assess the health (including the mental health) of the prisoner and not simply to judge their 'fitness' (eg for punishment).
- **Prisoners with long-term behavioural problems** should be assessed particularly carefully. They are at increased risk of developing stress-induced psychosis and of self-harm.
- It is recommended that prisoners held in isolation are assessed on a daily basis. Should a mental disorder be identified, the prisoner should be managed as described in **Prisoners who are mentally ill** above.

### *Use of physical restraints*

Doctors may sometimes be called upon to give advice about the appropriate use of mechanical restraints, which are more likely to be used in Segregation Units than in other parts of the prison. Currently, in prisons in England and Wales, where a patient has a medical condition leading to the violent behaviour, a doctor may order the use of 'medical restraint', ie the use of a 'special cell' or of a loose canvas restraint jacket. In addition, for all forms of violent behaviour, as a very last resort, a prison governor may order the use of 'mechanical restraint', ie the use of a body belt with metal cuffs or the use of special accommodation. Where a governor has ordered the use of either mechanical restraint or special accommodation, the role of the doctor is to assess whether there is any medical reason for not using these and if there is, to order their use to be ended immediately.

In the use of any form of physical restraint, the following are essential points of principle.

- It should be used as a last resort and for the shortest time possible.
- Steps should be taken to ensure the minimum possible invasion of the individual's dignity, eg audiences should be moved away.
- The individual should be treated in a way likely to calm rather than aggravate their aggression, eg speaking to them calmly and with respect.
- The individual's mental state should be assessed regularly and an urgent opinion sought from a psychiatrist if there is any history or current indication of mental illness, self-destructive behaviour or substance misuse.
- Where the patient has a mental disorder, care and treatment should be planned, if necessary and appropriate, under common law (see **Emergency treatment under common law**, page 168). Where indicated, steps should be taken to remove them urgently to a hospital where treatment can be given (see **Interface with the NHS and other agencies**, page 149).
- Where the patient has a history of very difficult behaviour, a full, multidisciplinary assessment and care plan should be arranged (see **Management of prisoners with complex presentations and very difficult behaviours**, page 202).

The relevant Prison Service instructions contain more detail about the management of prisoners who are segregated or physically restrained. Currently, in England and Wales, they are Prison Service Orders 1600 (Use of Force), 1700A (Management of Segregation Units) and 1700B (The Removal from Association of Prisoners Under Rule 45).

### **Isolation and mental health: a summary**

- There is a high risk that isolation, seclusion and segregation may damage mental health. The English Special Units Study, which looked at the treatment of some disruptive and dangerous prisoners, found that a subgroup had spent long periods in segregation and that psychotic symptoms had emerged, unbeknown to the prison staff.
- Some individuals can tolerate isolation better than others.

- People who are mentally ill and/or have other disorders such as emotionally unstable (borderline) personality disorder, antisocial personality disorder and narcissistic personality disorder are more likely than others to spend extended periods in isolation or segregation.
- Managing people at risk of suicide in 'strip cells' is against Prison Service instructions, as it is unacceptable and counter-productive.
- Prisoners who are mentally ill within the meaning of the Mental Health Act 1983 and who are held in segregation or seclusion because that is the only way they can be safely contained should be transferred immediately (within 24 hours) to a psychiatric hospital. It is an important standard for NHS services to work towards that such patients should be accepted by them within 24 hours.
- Where a prisoner held in segregation has any history or current indication of mental illness, self-destructive behaviour or substance misuse, an opinion should be sought from a psychiatrist and the appropriateness of relocating the prisoner in the healthcare centre considered. Where any current mental disorder is identified, a treatment plan should be drawn up and implemented.
- Frequent or extended use of segregation and, especially but not exclusively, transfer from the segregation unit in one prison to that in another to provide respite to staff, should trigger a multidisciplinary assessment and the development of appropriate multidisciplinary care plans. Such prisoners may benefit from admission to specialist units providing humane management approaches — such as those being developed for prisoners with 'dangerous severe personality disorder'.
- MSEs should be conducted on prisoners held in segregation, looking in particular for signs of stress-induced psychosis or depression. It is recommended that all prisoners held in isolation are assessed on a daily basis.
- Physical restraints should only be used as a last resort and for the shortest time possible. Steps should be taken to ensure the minimum possible invasion of the individual's dignity.

Potential ethical conflicts for staff

Quality of the environment

While work is in progress to improve the environment in prison establishments, for some prisoners the environment will contribute to the development of depression, anxiety and paranoia (eg restricted activity). Indeed, it can be argued that even where everything possible has been done to provide a humane environment, factors intrinsic to imprisonment itself — such as separation from loved ones and friends, the inability to make decisions for oneself, a lack of access to normal ways of coping — can have a negative impact on mental well-being. Healthcare staff have the professional responsibility to decide at what point prison conditions (such as overcrowding and a lack of activity) have deteriorated to such an extent that there is a professional obligation to take constructive action to bring about change.

Different priorities and perspectives

Other issues where conflict may arise involve the different priorities and perspectives of different groups of management and staff. For example, access to prisoners is controlled by lock-up times. Especially at night when staffing levels are at their most tight and escorts hardest to provide, doctors wishing to transfer a patient to A&E may come under pressure to deal with the situation within the prison. Healthcare staff may also request a particular type of location or treatment for a patient, but this may be seen as unfair to other inmates by non-healthcare staff or their managers, with the result that such arrangements may break down.

Resolving ethical conflicts

Staff, whether in the NHS or the Prison Service, have a duty to work to the highest ethical standards and to disclose situations they believe are damaging to standards of care.

If such a situation arises, healthcare staff should make a contemporaneous record in writing detailing the event and must pass on the information as soon as is practically possible. Concerns should be raised through the Prison Service's grievance procedure, which is set out in the Staff Handbook, paragraphs 21.1–21.5. In addition, all staff working in prisons are entitled to raise concerns with the Board of Visitors. Nurses and doctors may also wish to raise concerns with their respective professional organisations. Doctors should follow GMC guidance in relation to concerns about the medical practice of colleagues. All healthcare workers should be aware of the provisions of the Public Interests Disclosure Act 1998.

### **Potential ethical conflicts for staff: a summary**

- Staff, whether in the NHS or the Prison Service, have a duty both to work to the highest ethical standards and to disclose situations they believe are damaging to standards of care.
- Such situations may occur in relation to the quality of the environment in which prisoners are held or as a consequence of the different priorities and perspectives of different groups of management and staff.
- Such concerns can be raised through the Prison Service's grievance procedure, with the Board of Visitors or via professional organisations.

- <sup>1</sup> Department of Health, Home Office and Department of Education and Employment. *Working Together to Safeguard Children*. London, 1999.
- <sup>2</sup> Brownfield C. *Isolation: Clinical and Experimental Approaches*. New York: Random House, 1965.
- <sup>3</sup> Crassian S, Friedman N. Effects of sensory deprivation in psychiatric seclusion and solitary confinement. *International Journal of Law and Psychiatry* 1986; 8: 49–65.
- <sup>4</sup> Coid J. The management of dangerous psychopaths in prison. In Millon T, Simonsen E, Mirket-Smith M, Davis RD (eds), *Psychopathy, Antisocial, Criminal and Violent Behaviour*. New York: Guilford, 1998.
- <sup>5</sup> Royal College of Psychiatrists' Research Unit. *Management of Imminent Violence: Clinical Practice Guidelines to Support Mental Health Services*. London: Royal College of Psychiatrists, 1998.