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OFFICE OF THE INSPECTOR OF CUSTODIAL SERVICES

Thematic Review of Offender Health Services

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The Inspector's Overview

PRISONERS AS PATIENTS: PUBLIC HEALTH AND PUBLIC INTEREST CONSIDERATIONS IN ESTABLISHING AND SUSTAINING AN EFFECTIVE MODEL OF HEALTH SERVICE DELIVERY

Health services for prisoners and juvenile detainees are currently provided by Corrective Services, a department whose core business is certainly not health. There must always be a distinct possibility, therefore, that health services may be structurally marginalised. A whole cycle of prison and juvenile detention centre inspections carried out by the Inspector's Office had strongly suggested that this was indeed the case.

Accordingly, in April 2004, we embarked upon a thematic review of offender health services. This meant that, instead of having fifteen discrete pictures of health services in fifteen separate institutions, we could look at the Department's service provision as a system. Thus, we could assess whether such services and resources as were available were being utilised in an optimum way; whether staff deployment and attitudes were appropriate; whether linkages with external health providers, above all the Department of Health and its various specialist offshoots such as the statewide Forensic Mental Health service, were robust and effective; and more generally whether the overall service provision matched the needs of a population whose health status is almost certainly the worst of any identifiable sub-group in society.

This review thus involved extensive fieldwork in health centres; frequent discussion with health service personnel both within the Department of Justice (now Corrective Services) and within other service providers; the examination of documentation relating to budgets and rosters and the like; observations of other offender health services within Australia; and an extensive review of international literature and reports.

The evidence was clear: the systems that best served the public interest, as well as that of prisoner-patients, drew upon the principal health service provider – the agency whose core business was health rather than custody – as the health service provider for prisons.

In July 2005, we published a discussion paper (reproduced on the CD appended to this Report) setting out this view and the evidence that we had relied upon. The discussion paper was widely distributed for comment, and the responses are summarised in Chapter 6 of this Report. At that stage the Department of Health made no response, whilst the Department of Justice indicated its opposition to the central recommendation.

Subsequently, a draft report was written, taking account of the responses and drawing upon updated national and international documentation and experience. Apart from minor edits for clarity and accuracy, this Final Report reproduces that draft. The principal departments – Health and Justice – were invited to make formal responses.

The Department of Health responded by letter, dated 4 April 2006. I undertook to ensure that the views of the Director General, Dr Neale Fong, were fully represented within the Final Report, and accordingly his letter is set out below:

> There is nothing in the detail of the draft report itself that I would draw specific issue with. Our position remains that the Western Australian health system is currently stretched to meet the demands on it. Moreover, we are unaware of any evidence that would support the proposition that prisoner health services would improve simply by the transfer of the responsibility for their delivery from the Department of Corrective Services to the Department of Health. That is not to say that we do not believe they could be improved.
>
> In our view, improving prisoner health services is not simply a matter of additional financial resources. Prison health services are in essence specialised primary healthcare services. They require specialist knowledge and expertise in regard to the unique health requirements of a custodial population. Those skills and that knowledge of primary healthcare for those in custody are not to be found currently in the WA health system.
>
> The WA health system is predominantly one of hospital-based secondary and tertiary care, although we are progressing alternative approaches as we move through our reform program. Western Australian primary healthcare services are the domain of General Practitioners and community-based organisations that are largely Commonwealth funded. This is perhaps the background behind the historical resistance to suggestions that prisoner health services could be improved through their transfer to the Department of Health. On an evidence basis it would be difficult for me to support the proposed transfer for these reasons.

It would be inappropriate for me to comment directly upon Dr Fong's position. Readers of the full Report can assess for themselves the weight of his arguments.

What is very striking, however, is that the Department of Corrective Services has changed its position. At the discussion paper stage it rejected the core proposition that responsibility should be transferred across to Health. This view has now been replaced in its response to the draft report by an acceptance of the proposition that this is the right way to go. This is indeed a remarkable turnaround – a testament to the Department's new-found ability to question its own assumptions and pay regard to an evidence-based argument. Clearly, it now recognises that limitations on the present capacity to deliver health services constitute a risk, both legal and political. The formal responses to the recommendations are set out in Appendix 1.

Quite correctly, the Department also recognises that any such transfer would have to be done as a carefully structured transition with dual ministerial support. Certainly, neither the Department nor the Inspector would suggest that a major move such as this could be achieved without careful planning. The Report suggests that a two-year planning period followed by a two-year transition period would be realistic. Regardless of this, what is now clear is that the two departments are no longer singing from the same song book. The issue, I would suggest, is now irrevocably upon the public policy agenda.

The Australian Medical Association would seem now to support that view. Although no formal response was initially made to the discussion paper, a subsequent letter to the Inspector (15 May 2006) has indicated that the WA Branch 'has been concerned about the adequacy, or otherwise, of the Health Services for prisoners and would, subject to adequate resources and commitment, have little difficulty with your recommendations.' In addition, the national AMA has now put its weight and influence behind the proposition that 'all prisoners should be checked by mental health teams when received into custody, because of the high level of mental illness within jails'.[1]

The AMA national president also reiterated that prisoners should be allowed access to Medicare and the Pharmaceutical Benefits Scheme. Their exclusion is an anomaly that is both inequitable and defies any kind of logic. Although it was frequently mentioned to us in our consultations, invariably with a degree of frustration and even anger at the intransigence of the Federal Government in this regard, it was not specifically discussed in the draft report as it did not seem likely to be affected one way or the other by the issues with which we were primarily concerned. Having said that, perhaps if a mainstream health provider – the Health Department – provided health services in prisons, it would be somewhat more difficult for the Federal Government to resist a united stand by the medical profession about this matter than it is when a marginal health provider is responsible for services.

It is not the wish of the Inspector to try to bulldoze a policy change in this area. The circumspect and wide-ranging nature of the consultation process is testament enough to this. What is now apparent is that this policy issue – that in one way or another, with various inquiries, has been on the public agenda for at least 15 years – must be confronted sensibly and positively in a context where public health imperatives can only be fully achieved if prisoner-patients are understood to be integral to statewide health service needs.

Richard Harding
Inspector of Custodial Services

19th May 2006

1 ABC Online *AMA urges mental health checks for prisoners* (18 May 2006).

Chapter 1

BRIEF HISTORY OF THIS PROJECT

Deficiencies in prisoner health services became apparent to the Office of the Inspector of Custodial Services from the time its operations first commenced in June 2000. These deficiencies were manifest in areas such as dental services, mental healthcare, management of chronic illnesses, the control of blood-borne viruses and the availability of culturally appropriate health services for Aboriginal prisoners. It was also evident that service providers had very little accurate information about the epidemiological needs of the particular population, with the consequence that the available resources were not necessarily targeted to the best effect. In a context where the social determinants of health and the health status of offender populations, is markedly worse than that of the general population, resources and funding were clearly insufficient.

To compound matters, such services as were available were sometimes undermined by attitudinal values; the prisoner remained first and foremost a prisoner rather than a patient.

At our various inspections of prisons and juvenile detention centres, these broad observations were constantly reinforced, though a combination of a younger population, a greater allocation of resources and a more supportive culture meant that the problems with juvenile health were not as acute. Attachment 1 to this Report – attached as a CD – pulls together and synthesises the many observations that have been made about these matters in previous reports.

In this context, it seemed to the Inspector that an overarching or thematic review would be more productive than simply continuing to record deficiencies at particular prisons; the problem was systemic, not simply a collection of local problems. Accordingly, on 7 April 2004, the Inspector gave formal notice to the Department of Justice that a thematic review of prisoner and juvenile detainee health services would be carried out. The terms of reference were:

- To make an accurate inventory of existing services
- To assess the adequacy and effectiveness of those services in the context of resources, organisational arrangements and attitudinal or culture factors
- To make recommendations with regard to all aspects of health service delivery for prisoners and juvenile detainees.

The Offender Health Council, which is chaired by the CEO of the Department of Health, was notified on 16 April 2004. The principal official stakeholders were thus aware from the very outset that the thematic review would take place.

The methodology employed was as follows:

- An intensive inspection of five metropolitan prison health centres, conducted with the assistance of four external experts
- Follow-up visits at various times to the remainder of the prisons and juvenile detention centres in the WA system
- Visits to offender health service facilities in some other states
- An extensive literature review
- Discussions with a wide range of personnel, both managerial and front-line, in the Western Australian offender health services
- Discussions with persons responsible for the delivery of offender health services in other Australian States.

In July 2005, a draft report was circulated to the Departments of Justice (now Corrective Services [2]) and Health, as well as to a wide range of stakeholders both within the bureaucracy and representing NGOs and other interested parties, and comments were invited. Although described as a draft report, the previous paper thus took on more the format of a Discussion Paper, and it will hereafter be referred to in that way. Accordingly, at the Offender Health Council meeting of 5 September 2005, the Inspector informed the participants that a further draft report would be developed in the light of the various responses received and the evolving information. **The final Draft Report amended slightly the previous recommendations, and formal responses were sought from both the Department of Corrective Services and the Department of Health before publication and tabling in Parliament.**

The Discussion Paper contains a great amount of detail as to the operation of the WA system, but it is not proposed to replicate this fully in the final Draft Report. The Discussion Paper is attached in CD form as Attachent 1, and cross references will be made to it as necessary.

2 At the time this Review commenced, it was known as the Department of Justice. The name and organisational structure was changed from 1 February 2006. For the sake of clarity, it will be referred to as the Department of Justice when this is historically accurate and as the Department of Corrective Services when future developments are being discussed.

Chapter 2

INTERNATIONAL AND NATIONAL STANDARDS RELEVANT TO THE DELIVERY OF HEALTH SERVICES TO OFFENDERS

There is a plethora of relevant standards, and these were described in detail on pages 12-15 of the Discussion Paper. They can be summarised as (i) mandating the delivery of a standard of health services comparable to that available in the general community, and (ii) encompassing the human rights expectation that prisoners and juvenile detainees shall, from the point of view of their health, be treated first and foremost as patients and only secondarily as prisoners. This value is epitomised by such provisions as requiring that necessary medical care should not be withheld on the basis of discipline or punishment, that confidentiality of patient information should be respected and that no form of human research or experimentation in relation to patients should be permitted.

Some of the international and national standards are of long standing. Nevertheless, in 1995 the World Health Organization (WHO) commenced a Health in Prisons Project in recognition of the fact that there is a gap between public health and prison health. The dilemmas of melding good public health policies with prisoner health services were identified as follows:

> Prison is a unique setting with the possibility to address a wide variety of health issues and to meet the health needs of a target audience that is normally hard to reach. However, it must also be recognised that the setting has unique problems, which can be harmful to health, and the challenge is to maximise the opportunities for promoting health while attempting to reduce the negative factors that cause harm.
>
> The prison environment is often not conducive to good health. Prisons can act as breeding grounds for communicable diseases, can introduce prisoners to new, unhealthy practices (e.g. drug use, unsafe sex) and can seriously worsen a prisoner's mental health. Those entering prison have often had less healthy lifestyles than the general population, having been more likely to abuse alcohol, tobacco and illegal drugs, more likely to suffer mental disorder and at increased risk of contracting communicable diseases. Prison staff, too, may have unhealthy lifestyles, which can be significantly improved by vigorous programmes of health promotion, thereby also improving their productivity and morale.
>
> Prisoners are members of the general population: they come from and usually return to the community. So in terms of communicable diseases the relationship between prisoners' health, their families and the wider community is of acute concern. Limiting the spread of these diseases in prison benefits both the prisoner and the wider community.[3]

Even in Europe – generally regarded as the pacesetter in achieving good standards –closed institutions were somewhat isolated from the public health system. In other words, the key public health precept that preventive medicine, health promotion and cost-effective treatment

3 World Health Organization Health in Prison Project 'Why Promote Health in Prisons' http://www.hipp-europe.org/background/0030.htm.

are indivisible elements of good health policy applicable to the community's total health population was being ignored and undermined.

It should be noted that none of these international or national standards directly address the question of the model of health service delivery. They are concerned with the standards that should be achieved by whatever mode of delivery is relied upon in the particular jurisdiction. However, a question that is never far from the surface is whether the service delivery model is in itself a factor that facilitates or impedes the delivery of those services to the required standard.

Indicative of the growing recognition of the importance of linking prisoners' health effectively to public health, a new international journal – *The International Journal of Prisoner Health* – was founded in 2005. In the preface to the first issue, distinguished personnel[4] closely associated with the WHO Health in Prison Project stated:

> The launch of this … journal comes at an important stage in the development of effective services to improve the health of prisoners. The relative neglect of prison health by both public health and prison authorities, which characterised most of the last century, is at last being replaced by a growing acceptance that prison health is an important component of general public health. [5]

This is a key point in discussing what should be the best model of health service delivery for offenders in prisons and juvenile detention centres in Western Australia. It seems relatively clear from the evidence in this Draft Report that a health service model that looks inwards, concerned with patients only whilst they remain prisoners, is not well-equipped to meet widely agreed public health standards.

4 Moller, L and Gatherer, A 'Preface' *International Journal of Prisoner Health* 1 (2005) 1,7.
5 Moller, L and Gatherer, A 'Preface' (2000) 1(1) *International Journal of Prisoner Health,* 7.

Chapter 3

AUSTRALIAN ISSUES

The problem of the disconnectedness of health services for incarcerated populations from the general precepts of integrated public health policy had been recognised in Australia. From the early 1990s, health service professionals concerned with the health of incarcerated populations have been meeting regularly to identify these gaps and take measures to rectify them.

In Australia, and particularly in Western Australia, these gaps are wide because of the prevalence of Aboriginal people in the prison and juvenile detention systems. It is well understood that Aboriginal health profiles are far worse than that of the general Australian population, both as to mortality and morbidity. With about 1,400 Aboriginal prisoners and 100 or so Aboriginal juvenile detainees, a perspective with regard to the delivery of offender health services in Western Australia is that the Department of Corrective Services is in effect trying to run the biggest single Aboriginal Medical Service in the state (though with almost no Aboriginal staff). A further perspective is that, in relation to the 2,000 or so other prisoners and detainees, the Department is running a general practice for a population whose health status and needs require more extensive services than the general civilian population.

The Discussion Paper (pages 7-12) documents the various responses by way of Review or Royal Commission to these perceived problems. The first of these was the Royal Commission into Aboriginal Deaths in Custody.[6] Recommendations 150-157 of that commission, whilst emphasising the general need to attain community standards for all incarcerated offenders, naturally concentrated on the particular and acute needs of the Aboriginal detained populations. In a reaction to the recommendations of the commission, the Department of Justice, as early as 1990, strongly expressed the view that 'the prison medical service must remain under the control of the Executive Director Prisons … The efficient and effective management of prisoners rests upon a "whole person" approach in which it is essential that all aspects of care, custody and welfare are facilitated.'

In 1997, Sir William Deane, then the Governor General of Australia, launched the health and welfare policy of the Aboriginal and Torres Strait Islander Peoples and the first national Indigenous Health and Welfare Report. After explaining that the new report series was a joint venture of the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, he stated:

> The … Report confirms a further alarming fact that the gap between the health levels of Aboriginal and Torres Strait Islander peoples and other Australians is actually widening … It is often suggested that Indigenous health and welfare are not as great a problem in our capital cities as they are in outback areas. The Report's statistics for Western Australia, South Australia and the Northern Territory go a long way towards negativing that suggestion.[7]

6 Royal Commission into Aboriginal Deaths in Custody (RCIADIC), *Recommendations* (2001).
7 Sir William Deane: www.gg.gov.au/speeches/html/speeches/1997/970402.html.

This statement served to put the health status of Aboriginal prisoners into the wider health context, emphasising the urgency of achieving improvement in overall Aboriginal health status wherever, whenever and however possible. Subsequently, the *National Framework for Aboriginal and Torres Strait Islander Health* has been developed and endorsed at Cabinet level in all jurisdictions. This framework document grants priority status to the healthcare needs of Aboriginal prisoners.

In 1998, the WA Department of Justice, with the leave of the then Government, decided to test the private market for the delivery of a total package of offender health services. In the event, the initiative fell over through a combination of costs and bureaucratic wrangling. The point for present purposes, however, was that the key official stakeholders could now see, as they could not in 1991, the need to explore an alternative model of service delivery.

In 1998, the State Ombudsman commenced an inquiry into deaths in prisons in Western Australia and his report was presented in December 2000.[8] The Ombudsman documented numerous problems and deficiencies with health services available to prisoners at that time and recommended that the 'planning and delivery of prisoner health services should be the responsibility of a body entirely external to [the Ministry responsible for running prisons]'. The basis of this was to safeguard funding against incursions by those whose job it was to run the prison system as a whole and to ensure that prisoners were first and foremost treated as patients in relation to their health needs.

In June 2001, the Health Administrative Review Committee, set up by an incoming Government that was mindful of the crucial community importance of good public health systems, recommended that 'the Government give consideration to transferring responsibility for Prison Health Services to the Health Department of WA.'

The questions of the model and practicalities of service delivery had by 2001 thus emerged as pressing ones in Western Australia.

8 That inquiry was carried out of his own motion. It commenced before the Office of the Inspector of Custodial Services was established.

Chapter 4

MODELS OF DELIVERY OF OFFENDER HEALTH SERVICES

There were three main models of offender health services operating within Australia at the time of the Discussion Paper. These were:

- A Health-managed model
- A Justice/Corrective Services-managed model
- A mixed model.

The Health-managed model is calculated to maximise the links between prison and detention centre health services, on the one hand, and the public health system, on the other. The very fact that it is managed by the same authorities responsible for the general management of health in the broader community means that better integration is likely to be achieved. Within Australia, the two main examples of this model were at that time, New South Wales and South Australia. Tasmania had also recently switched to this model, though some anomalies in the precise management responsibilities seemed to persist.

With regard to a Corrective Services-managed model, its essential characteristic is that the department responsible for custodial services also manages the health services. This is the current situation in Western Australia and also, at the relevant time, in Queensland.

Victoria can be seen as an example of a mixed model. Although Corrections Victoria is responsible for funding prison-based health services, it does not directly employ health professionals, as in Western Australia, but purchases these services from both public and private providers. In fact, there are five contracts and several sub-contracts with four separate providers – GEO, Pacific Shores Healthcare, Saint Vincent's Hospital and Forensicare. In other words, it is so dependent on outsourcing to specialist health professionals and service providers that it is somewhat misleading to equate it with a Corrective Services-managed model of the sort that provides services directly. As will be seen, the whole arrangement seems extraordinarily complex and cumbersome.

In more detail, St. Vincent's Correctional Health Service provides primary healthcare and out-patient mental healthcare for Port Phillip Prison patients, statewide secondary in-patient healthcare at Port Phillip's St. John's ward, and statewide tertiary services from St. Vincent's closed ward (St. Augustine's). These services are provided by way of a sub-contract with GSL, which holds the head contract with Corrections Victoria. GEO, the operator of Fulham Prison, provides primary healthcare and mental health services at Fulham Prison itself. A subsidiary of GEO, Pacific Shores Healthcare, provides primary healthcare at nine public prisons, whilst St. Vincent's provides such care at two public prisons.

To add to the complexity Forensicare, which is a separately-funded and managed statutory authority reporting through the Department of Human Services, provides psychiatric consultancy and registrar services to all public prisons and also manages the 15-bed in-patient acute assessment unit at the Melbourne Assessment Prison (this aspect of its service is funded by Corrections Victoria). It also runs the health services at the Thomas Embling Hospital, which has 100 forensic patients, the majority of whom have come there through some aspect

of the criminal justice or prison system.[9] The custodial security services at Thomas Embling are the legal responsibility of Corrections Victoria, which has, in turn, contracted them out to GSL, the operators of Port Phillip.

The Victorian system is by far the most complex within Australia though, despite what seem to be confusing lines of responsibility, from the perspective of the outside observer its outputs seem on the whole quite impressive. As will be seen later, it is also among the best-funded. However, its very complexity has led to some concerns as to the achievement of consistent standards across the system and the ability to monitor those standards effectively. The arrangements are currently under review.

The Northern Territory also operated a mixed system. The Correctional Services branch of the Department of Justice has managed the outsourced primary healthcare contracts since 1993. These outsourced or privatised services are operated in conjunction with psychiatric services provided by the Department of Health and Community Services through its forensic mental health service. As in Victoria, these arrangements are also under review. It is understood that a commitment in principle has now been made to a transfer of responsibility for offender healthcare services from Justice to the Department of Health and Community Services, and that preparatory steps involving an independent audit of services, facilities and resources and discussions with relevant organisations representing Aboriginal interests have commenced. The expectation is that a final decision to implement such a transfer will be made by mid-2007.

In a sense, all jurisdictions have somewhat mixed models; there are no 'pure' models. A Corrective Services-managed model such as that in Western Australia draws upon services from the Health Department and from private providers as required; likewise, a Health-managed model such as New South Wales draws upon private providers as required. Nevertheless, it is accurate to say that there are three recognisably different basic models of health service delivery within Australia – Health-managed, Corrective Services-managed, and mixed.

This in itself, would seem to suggest that the time is overdue for an assessment of the optimum way in which to deliver such services. Indeed, there have been, and currently are, numerous recent reviews; change is definitely in the wind.[10] Although the concern of this Draft Report is with the Western Australian situation, there may be some benefit in thinking about these matters from a national point of view. In that regard, it is worth noting that during

9 The Annual Report of the Victorian Institute for Forensic Mental Health 2004/2005, shows that the occupancy rates of the Thomas Embling Centre patient mix averaged over the year and at the census date were, respectively, 87 per cent and 95 per cent from the criminal justice stream and the remainder from the civil law stream. See pages 18–19.

10 New South Wales after a review extended the 'Corrections Health Service' from prisons to its juvenile institutions in 2004 and re-named it the 'Justice Health Service.' Victoria is currently reviewing its complex model and one of the several possible outcomes is that it could revert to the Health-managed model that had been in existence until about 1991. Queensland is reviewing its model at the behest of the newly created office of Chief Inspector of Prisons. Tasmania reviewed its model following the Ombudsman's 2001 report into deaths at Risdon Prison. As described in the text, the Northern Territory commenced a review in 2005 and its recommendations are being considered. South Australia, in the fallout from the Palmer Inquiry into the detention of Cornelia Rau, is reviewing its system for the delivery of forensic mental health services to prisoners.

2005 the Australian Health Ministers Advisory Council (AHMAC) placed the question of prisoner health services as an item of core significance for its future deliberations and policy development, thus mirroring in a general health context the previously described priority agenda of the *National Framework for Aboriginal and Torres Strait Islander Health*. The national Australian Medical Association has also indicated its concern about the quality of prisoner health services.

Chapter 5

RECOMMENDATIONS OF THE DISCUSSION PAPER

In the light of the evidence gathered and the analysis of the present practices, the central recommendation made in the Discussion Paper was that **'responsibility for the provision of health services for prisoners and juvenile detainees should be transferred from the Department of Corrective Services to the Department of Health.'** It should be emphasised that such a recommendation does not necessarily involve the notion that the Department of Health should directly deliver all of the requisite health services through its own employees or using its own facilities. As with civilian models of health service delivery, the discharge of the responsibility would involve a complex patchwork of direct service provision and contracted out service provision.

It is also important to emphasise that the responsibility for custodial management of those patients, not just within the custodial setting but also whilst they are out-patients or in-patients within a health service environment, would remain with the Department of Corrective Services as the custodial service provider.

Several consequential recommendations flowed from this central one, in particular with regard to transition arrangements. There were also some key recommendations as to matters that should be dealt with, whether or not a transfer of responsibilities to the Department of Health occurred. Foremost amongst these was that a health status survey of the prisoner and juvenile detainee populations should be carried out so as to ascertain service needs and that funding levels should be realistically costed so as to be brought into line with the needs-base of these populations.

In that regard, it must be emphasised that to attain a 'community standard' for this population inevitably involves a far greater disposition of resources than would be the case in relation to a random cross-section of 3,500 non-custodial persons across the state. Rather as with an aged persons' home or a residential drug rehabilitation centre or a dialysis clinic, prisons bring together people from various communities who are individually more in need of health services than average. The Victoria Prisoner Health Study 2003 captured this point in its statement that: 'Numerous indicators suggest that the prisoner population is a distinct cohort, rather than a microcosm of the wider community.'

In a non-prison environment a 'community standard' reflects and averages out the service needs of the worst, as well as the best, segments of the health population. Thus, if the worst part of the health population happens to be gathered together in one place or within a single part of the health service system, the notion of 'community standard' refers to the overall level of service that they need and would receive if they were scattered as individuals throughout the wider community.

This point needs stating, even labouring, because of the frequency with which one encounters the view that a 'community standard' is met by providing health resources equivalent to what would be provided to a random group of similar size. In other words, **the standard should be needs-based**, because a needy population has been gathered together in one place rather than being left distributed randomly around the community.

Chapter 6

RESPONSES TO THE DISCUSSION PAPER

Not a single respondent considered that the current level of health services met the needs of the relevant population. All agreed that more funding and resources were required. Most made this point explicitly, whilst the Health Services Directorate of the Department of Corrective Services did so obliquely by referring to its lack of success in seeking additional funds for a variety of initiatives.[11] Its voice could not effectively be made audible in a competitive environment both within the Department itself and across Government as a whole.[12] In other words, no one – not even the Corrective Services and the Health[13] Departments, being those most directly involved in the present system – could be found to defend the present situation. From a public health point of view, there was no dissenting voice that offender health services fall short.

There was also widespread agreement that the overwhelming need was to bring about improvement in the health status of prisoners, however it was done. The Deputy State Coroner encapsulated this view with her comment that 'the health of prisoners generally should be improved regardless of whether it is ultimately a Health Department or a [Corrective Services] Department responsibility.' Various respondents highlighted the services that particularly needed to be improved: Aboriginal health; mental health; intellectual and physical disability services; adolescent health; and women's health.

There was strong support for the core recommendation of the Discussion Paper – that transfer of responsibility to the Health Department was a necessary prerequisite to achieving across-the-board improvements in service provision. The Council of Official Visitors endorsed 'the Review's claim for a health-managed model.' The Health Consumers' Council stated that 'the report confirms the strong conviction held by this organisation that the provision of health services in prisons and other detention facilities should rest under the jurisdiction of Health and not be under the control of the Department of [Corrective Services] … This report offers the opportunity for a substantial change in healthcare in this state that should be seen as a great step forward, not an onerous and burdensome challenge.' Outcare 'agreed with the report's findings and recommendations.' The Aboriginal Legal Service found the report 'true to ALSWA's experience.' It agreed that the prison experience represented a window of opportunity for addressing some of the chronic health issues of Aboriginal Australians and that this could best be done via a Health-managed model. The Prison Reform Group of

11 In its response to the Discussion Paper, the Department of Justice stated that: 'Justice Health Services competes with other priorities *with the Department* and other government Departments in regard to funding. Deficient areas have been identified – chronic disease management (Aboriginal health), dental care, mental health and Hepatitis C – and funding has been sought, however has previously been unsuccessful.'

12 At our request, the Health Services Directorate subsequently supplied its costed bids to develop its services to cover its perceived needs. These amounted to $8.25 million dollars in Year 1 and $32.2 million over a four-year period.

13 The Health Department Executive chose not to respond directly at this stage, though two offshoots – the Office of Health Review and the Drug and Alcohol Office – made their own independent responses. The Inspector met with the high-level representative of the Director General of Health on 18 March 2005 and was informed that he personally did not disagree with any of the views put forward, though he could not of course speak for the Director General or the Minister.

WA 'strongly recommends that the latter model, that of moving responsibility for prisoner healthcare to the Health Department, be implemented.' The Deaths in Custody Watch Committee also supported transferring responsibility to Health.

It is noteworthy that the strongest support emanated from organisations or individuals who have the most to do with prisoners and therefore are most conversant with their frustrations and needs. The position of bureaucratic or official sources was generally more guarded. For example, the Office of Health Review, having noted that there has been a marked increase in complaints from prisoners about healthcare over the past few years, nevertheless, 'did not have a particular view or preference one way or another' and envisaged 'difficulties with either model.' Similarly, the Drug and Alcohol Office did not express a preference, though noted that 'prison drug programs have encountered resourcing, planning and implementation difficulties that have impaired their effectiveness.' The Ombudsman, whilst supporting the position that a Corrective Services-managed model was not ideal and that her predecessor's report had 'supported the establishment of an independent prison health service,' noted that such a service could be structured in a different way from transfer to Health, though it was not suggested what form this might take.

A personal submission from a general practitioner, who was currently working at more than one prison, considered that some kind of Custodial Health Services Board might be set up as the management authority and funding authority – separate from both Corrective Services and Health.

Several respondents, whilst implicitly supporting the main proposal, doubted the good faith and commitment of Health. The Deputy Coroner expressed concern 'that there will be resistance to the concept of transferring prisoner health to the Department of Health as it is currently trying to divest itself of any areas involving the Department of [Corrective Services].' A former senior bureaucrat doubted whether funding bids would do any better if put forward by Health rather than [Corrective Services]. The Prison Reform Group also considered that any transfer across would need to be matched by a cultural change within the Department of Health: 'Prisons do not adequately cover prisoners' healthcare needs because it is not a core business activity and thus not a priority. Health does not adequately cover the healthcare needs of prisoners because, although healthcare is a core business activity, prisoners are not part of their mandate and thus their care is not a priority.'

The only explicit opposition to the main proposal came from the then Department of Justice. The main argument put forward was that transfer of the service would 'expose more risks,' including:

- Loss of identity – the Department's Health Services Directorate has matured into an entity that is capable of delivering health services to patients in custody
- Loss of focus – if transferred into a larger organisation there is the strong possibility that the focus of healthcare for patients will be diverted or lost
- Competing priorities – it is generally acknowledged that the Department of Health budget is under extreme pressure due to competing priorities within the Health Department to meet the needs of the general population. Examples of this are mental and dental health.

The Department added that 'a full risk management strategy needs to be conducted and evaluated before any changes are made' – a point that was clearly flagged in the original proposal for a transition period.

There were very few individual responses from health professionals working in the Justice Health Services Directorate. This was something of a disappointment as the Discussion Paper had been distributed by email (twice) to nurse-managers at each institution. Nevertheless, conversations with Directorate health professionals working in the field indicated a fair degree of support for the main proposal, often on the basis that the Service was professionally marginalised from the rest of the health profession, and that this was to its detriment. The one nurse-manager who responded in writing argued cogently that the Service was declining, and cited cultural, funding and management issues.

Other responses to the Discussion Paper highlighted substantive health matters that should, in the eyes of the commentators, have received fuller attention. These included: physical and intellectual disability; adolescent and juvenile health needs; and mental and psychiatric health needs (the needs of this particular segment of the offender population are so great that no amount of coverage of mental health in the Discussion Paper could be excessive).

In summary, the range and thrust of responses were such that the Inspector is now absolutely confident that the broad directions of the Discussion Paper were appropriate and timely. In the context of the other recent and current health service reviews in Australian Corrective Services settings, plus growing interest at the levels of the medical profession and national governance systems, this is a matter that will not, and should not, go away. It has to be resolved within a reasonable time, rather than being permitted to drift.

Chapter 7

COSTS OF OFFENDER HEALTH SERVICES IN AUSTRALIA

There can be no doubt that the potential cost of these services is a factor influencing the official and bureaucratic responses. Without putting exact figures on it, official and bureaucratic respondents well understand that the services are currently under-funded. Transferring them to Health would cause two effects: (i) to bring the spotlight on to a health service in a way that does not happen when the service is provided by a department whose core business is not health; and (ii) to make it professionally and ethically impossible to continue to deliver services at a level that falls well short of reasonable needs. In other words, it is the very fact that responsibility for offender health services resides with a non-health provider that enables it to continue to be sub-standard.

That being so, in a climate where offenders are increasingly stigmatised by politicians and the media, it is tempting for governments to structure offender health services in ways that keep the costs down rather than commit to the costs of implementing a needs-based health service. They well understand that expenditure of any kind on offenders is a favourite issue for those who believe in 'wedge politics.' However, seen from a public health perspective, well-targeted health expenditure should properly be seen as a down-payment towards the reduction of future health costs that would be incurred by that population following release into the community.

The Discussion Paper (22-25) attempted to identify offender health costs by state, so that some comparators could be established with regard to the services provided in Western Australia. One consequence of complex and/or split models of prisoner health services is that it is extremely difficult for an outsider, and even the service provider itself, to make an accurate estimate of the true costs.[14] It is not irrelevant to note that the two states whose services are health-managed – New South Wales and South Australia – could, with reasonable confidence, put a cost on their services, as could the pay-for-service Victoria system, whereas Western Australia and Queensland, as the principal Corrective Services-managed systems, were the least able to do so.

In South Australia, the 2003/04 budget was $12.2 million for a total average daily prison population of 1,650. That is an average of about $7,400 per annum, per prisoner-patient. This figure does not include the privately managed Mount Gambier Prison, however. In 2004/05 the NSW annual budget was $67,573,000; this is an increase of about one-third (or $17 million) since 2002/03, which partly reflects the takeover of juvenile offender health services but also is indicative of the degree of commitment in that state to maintaining appropriate prisoner health services. The expenditure per prisoner patient per annum, based on average daily populations (adult and juvenile) of about 8,900 is about $7,600.

14 In the discussion that follows, the costs of transporting prisoners to and from outside medical appointments are not included, nor are the costs of bed watches for hospitalised prisoners. These should be seen as custodial costs – though it is obvious that a system that treats a large proportion of patients in a prison setting or one that utilises a locked ward within a hospital for tertiary care will have reduced costs.

Western Australia had considerable difficulty in quantifying its costs. The best one can say is that in 2003/04 they were of the order of $14 million, made up of $12 million direct Department of Justice costs and about $2 million Health Department costs not charged to Justice – ie., specialist appointments at hospital out-patient clinics, stays at tertiary hospitals, pathology services, some dental services, some psychiatric services. These costs related to an average daily public prison population of about 2,400 (now, in mid-2006, about 2,800). In addition, there were about 700 prisoners at the privately managed Acacia Prison.

For the public prison population, it could thus be said that the average per prisoner per annum expenditure was thus of the order of $5,800. The costs are lower than this at Acacia – about $2 million per annum for a daily average population of 730, working out at about $2,700 per prisoner.

The Department's own figure for 2003/04 is lower than this, at about $4,450 per annum; this figure appears to represent an average of the public prison and the Acacia costs and possibly does not fully reflect the subsidies received from the Department of Health. Subsequently, the Department has offered yet another cost estimate – $4,263 per public sector prisoner for 2004/05 with a total direct budget of $11.6 million. It is certainly surprising that the budget in this key area is actually decreasing. No less surprising is the fact that there is such confusion surrounding budgetary figures.

In Queensland, the Director of Health Services appears to have very little control over budgets, which are apparently subsumed within the budgets of individual prisons. It is difficult to envisage in these circumstances how Health Services can have adequate input into priorities and service quality. It was reported to this Review that 'budgets for staff, pharmaceuticals, and consumables at each [correctional] centre are funded by that centre.[15] It was thus well nigh impossible to put an overall figure or a cost per prisoner figure on health services. From the point of view of accountability and informed debate, the Queensland position is even less satisfactory than that in Western Australia.

In the Northern Territory, the 2004/05 budget for adult and juvenile health and related services, managed by the Department of Justice, was approximately $2.4 million. This budget was exclusive of all services provided by the Department of Health and Community Services (pathology, accident and emergency, specialists, X-Ray, in-patient care, transfers for surgery and specialist care) and other allied health providers (STI/BBV counselling, etc).

In Tasmania, recurrent costs have not been sufficiently differentiated from capital costs for a meaningful per prisoner per annum cost to be identified.

In Victoria, the Correctional Health Services budget for 2003/04 was reported to be $23.4 million, which covered all of health – from primary to tertiary – purchased by the Department of Justice. The costs of running the Thomas Embling Centre were a further $32 million per annum; about 90 per cent of these costs are attributable to a population that would otherwise be incarcerated in the prison system.[16]

15 Director of Health Services, Queensland, email (24 March 2005).
16 Corrections Victoria does not accept this figure, but the published data seem clear.

Thus, the costs going through the Justice budget work out at about $6,700 per annum per prisoner-patient in relation to the daily average population. If the highly specialized forensic services supplied at the state-of-the-art Thomas Embling Centre were added in, as if they should be spread across the whole prisoner population, the average would be in the order of $15,000 per prisoner. Of course, the funding goes through a different budget, but in practical terms it is nevertheless 90 per cent prisoner health service funding.

Returning to the situation in Western Australia, the average per prisoner figure – whether it is $5,800 or $4,450 or $4,263 – conceals a wide range, from $19,825[17] for Rangeview, the juvenile remand centre, to $1,678 at Karnet, a minimum security prison for prisoners nearing the end of their sentences. Expenditure at the 'Aboriginal prisons' of Broome, Eastern Goldfields, Greenough and Roebourne amounted to $3,948 per head per annum. This level of funding does not adequately reflect the burden of need in these populations. To highlight this point, in 2003/04 the Brewarrina Centre in New South Wales, an 'Aboriginal prison' by our own definition, [18] has a total health budget for 50 prisoners of $416,000 ($8,320 per head per annum) – more than twice as much as in comparable WA prisons. [19]

The WA average annual cost per prisoner is, at the top estimate of around $5,800, about 30 per cent short of the benchmark figures for South Australia and New South Wales, and about 17 per cent short of the Victoria figure for standard healthcare (ie., excluding Thomas Embling)[20] If the lower figure of $4,450 is taken as the correct one, WA expenditure is about 40 per cent short of the NSW and South Australia benchmark and 33 per cent short of the Victoria figure. Of course, if the Thomas Embling costs attributable to criminal justice system patients are included in the Victoria benchmark figure (and there is no logical reason why they should not be), Western Australia's per prisoner per annum expenditure is a mere 30 per cent to 39 per cent of the Victoria figures.

These figures may provide some indicative benchmark of the difference between a Corrective Services-managed model, that tends to suppress demand, and a Health-managed model, that sees public health expenditure on vulnerable populations as a long-term investment. They are indicative figures only, however. For it should be noted that WA's prison population contains a far higher percentage of Aboriginal prisoners (at 40% plus) than does either of the benchmark jurisdictions – persons with a far worse health profile and thus greater health service needs than non-Aboriginal prisoners. Thus, the shortfall is in reality likely to be even greater than it might at first seem.

17 Department of Corrective Services 2005/06 Budget July 2005.

18 ie. one whose normal population is 80 per cent or more Aboriginal.

19 Roebourne is the most expensive of the Aboriginal prisons in terms of health costs. For 2005/06 the budget is $690,029 (for 170 prisoners). This equates to an annual per head expenditure of $4,058, still well short of the 2003/05 figures for Brewarrina.

20 If the costs of the Thomas Embling Centre were taken into the equation and Victoria treated as a benchmark, WA would be about 125 per cent below the desirable figure. However, the level of service provided by that centre – conceptually and in practice a 'centre of excellence' – so far exceeds what else is available within Australia for forensic patients that it is unrealistic to treat it as a benchmark. When the new Long Bay Forensic Hospital in NSW is completed and is operational, however, the per prisoner per annum average expenditure in that state can be expected to rise substantially, at which point the benchmark figure can quite realistically and fairly refer to the Victoria/NSW position.

The debate about the most equitable model of prisoner health service provision, the model that best meets public health needs, should thus be conducted on the basis of a rough estimate that an appropriate level of service might work out at about $8,000 – $10,000 per prisoner per annum or, on the WA prisoner population as at May 2005, at about $28 – $35 million per annum. To bring offender health services up to a benchmark figure would involve at the very least doubling the current expenditure.

Of course, that is what frightens bureaucrats and politicians. An additional outlay of $14 million per annum is obviously not in itself attractive to Government. But in the total scheme of contemporary healthcare costs, that sum is a drop in the bucket. It would be shameful for the debate about the optimum mode of providing prisoner healthcare services to descend to the point of being simply a costs argument. It would also be foolish, for **the likely payoff for a public health investment during the window of opportunity presented by the presence of a high-risk health population in a controlled environment would in all likelihood far exceed the investment.**

Chapter 8

THE HEALTH STATUS OF OFFENDERS IN CUSTODY IN WESTERN AUSTRALIA

Reference has already been made to the poor health status of offenders in custody in Western Australia and the consequential requirement that funding and resources should be needs-based. This matter was discussed in the Discussion Paper on pages 39-47 and at various points between pages 50-78.

An accurate picture of the health status of a population is self-evidently a prerequisite to productive planning and cost-effective delivery of health programs. Unfortunately, Western Australia does not have a reliable health profile of the detained offender population. Of course, there are bound to be commonalities with offender populations in other states, so information as to their health status will possess some utility. On that basis and drawing also upon such empirical data as do exist in Western Australia, we can certainly say with confidence that the health status of offenders is markedly worse than that of the general population.

Three Australian States – New South Wales, Victoria and Queensland – have conducted clinical and statistical surveys of their prison populations to ascertain the overall health status. The Northern Territory has now committed to an epidemiological survey of the health needs of the incarcerated offender population to be carried out in 2006. The purpose of these surveys has been to enable services to be prioritised according to actual needs. It should also be stressed, that accurate knowledge of the profile of its health population was a key factor enabling Corrections Health (now Justice Health) in NSW to supplicate successfully to Government for funds sufficient to provide the required services.

In New South Wales, the data from the *2001 Inmate Health Survey*[21] – the follow-up to the 1996 Survey – has enabled the health service needs to be identified and quantified. It was, for example, ascertained that:

- 31 per cent of women and 28 per cent of men tested positively for hepatitis B (lower than in 1996)
- 64 per cent of women and 40 per cent of men were hepatitis C positive
- 95 per cent of women and 78 per cent of men had at least one chronic medical condition
- 33 per cent of females and 50 per cent of the males drank alcohol in hazardous quantities
- the rates of mental illness were extremely high
- 83 per cent of women and 78 per cent of men were current smokers.

These observations, in turn, could readily be disaggregated so as to show health differences between Aboriginal and non-Aboriginal prisoner groups – for instance, that the prevalence of hepatitis C amongst Aboriginal prisoners had markedly increased over a period of five years, whereas that amongst non-Aboriginals was static. Obviously, findings such as these should be the drivers of health services in prisons, particularly those with high percentages of Aboriginal prisoners. As Butler has pointed out, from the point of view of anticipating and planning for

21 Butler, T and Milner, L *The 2001 New South Wales Inmate Health Survey.* (New South Wales: Corrections Health Service,) 8-9.

public health trends, 'prisons can actually be used as *sentinel sites* to monitor outbreaks in hard-to-access communities.' [22]

These findings are even more informative when compared cross-jurisdictionally. For example, the 2003 Victorian Prisoner Health Study[23] indicated very similar prevalence of hepatitis C amongst Aboriginal prisoners, confirming that the emerging public health problem is genuine and widespread. From a health policy point of view, Butler's notion of 'sentinel sites,' is a compelling one.

Western Australia has not carried out similar surveys; a cohort analysis based on existing medical records is so far the nearest approximation. The methodology for this analysis involved paper-based surveys of prisoners, dependent solely upon medical records and not supplemented by interview and medical examination. However, even at this superficial level of research, this report highlighted that all health problems that were analysed were over-represented in the prison population in comparison to the general community. These conditions included: blood-borne viruses, asthma, cardiac conditions, diabetes, epilepsy and psychiatric issues. Intellectual impairment and general physical disability were also greater for inmates than the general population.

A retrospective study of prisoners released from prison between 1995 and 2003 was recently carried out by Michael Hobbs et alia, with the assistance of a Criminology Research Council grant, and was released in 2005.[24] Although a comprehensive health status survey of the existing population at any given moment is methodologically preferable from the point of view of ascertaining service needs and priorities, this study was nevertheless useful and informative. Released prisoners living in the community were found to have substantially higher risks of death, adjusted for age, than the general population. The risk was highest in the first six months after release, and the most vulnerable sub-population was Aboriginal ex-prisoners. Released prisoners also had substantially higher hospital admission rates or contacts with the mental health system, adjusted for age, than the general population, and once more the Aboriginal sub-population was even more over-represented, not only in relation to the general population, but also in relation to the total Aboriginal population.

The study analyses causes of death, morbidity and mental health system contacts in considerable detail. They broadly tie in with the patterns that other studies would lead one to expect. The point for present purposes, however, is twofold: prison does represent a window of opportunity from a health point of view but is apparently not being sufficiently pursued, as demonstrated by the high mortality rates in the first six months post-release; and the need for throughcare and effective linkage with the general health system after release is crucial and appears not to be adequately achieved, as evidenced by the high rate of hospital admissions and mental health system contacts.

22 Butler, T, *Background paper presented to the National Health Indicators Project Workshop*, (September 2004).
23 Department of Justice, *Victoria Prisoner Health Status Study* (February 2003).
24 Hobbs, M, Kraszlan, K, Ridout, S, Qun Mai, Knuiman M and Chapman, R *Mortality and morbidity in prisoners after release from prison in Western Australia 1995-2003* (Unpublished).

In the absence of reliable data arising from comprehensive surveys, the understanding of the health needs of the WA prison population is somewhat impressionistic, based on the observations by health staff of those prisoners who actually present as patients from time to time. Health Services management have an assumed, rather than an empirical, understanding about the health needs of the prisoner population. As with all health populations, some individuals and sub-groups tend to present more readily than others, whilst others prefer not to present at all. Thus, a profile derived simply from case records will inevitably lose the accuracy of either a comprehensive survey or one that is derived from structured random samples. Neither the extent of health conditions nor the social determinants of health are currently known with any precision.

Health Services recently submitted a business case to the Prisons Executive for approval of a new Electronic Health Information System.[25] The aim of this new system will be to improve access to patient information and provide a consistent approach to delivering healthcare throughout the state prisons and detention centres. It is suggested that this system will be a step closer to linking health centres and ensuring that access to information is quicker. It is also anticipated that this system would assist with inmate health surveys – though again only in relation to prisoners who present as patients rather than with a truly random cross-section.

It cannot be assumed that prisoner health profiles will be consistent across jurisdictions, particularly in the context of 40 per cent Aboriginal adult custodial population in this state. Therefore, it is crucial that there should be a survey that identifies the particular characteristics of WA prisoners. This could be by participation in the proposed National Prisoner Health Indicators Survey or as a stand-alone exercise. If the former, it is essential that an adequate sample reflecting the WA prisoner population be comprised within the national sample, so that disaggregated data possess the required validity.

Anticipating the broad thrust of findings of any such National or State Prisoner Health Indicators Survey, it is likely that the main areas requiring attention within the WA offender population would be as follows:

- Women's health issues
- Mental health issues
- Prior drug use by offenders
- Cardiac conditions
- Diabetes and renal conditions
- Hepatitis C and other blood-borne viruses
- Sexually transmitted infections
- Health issues particular to adolescent and juvenile offenders
- Dental care issues
- Intellectual and physical disabilities, including geriatric issues, amongst offenders
- Aboriginal health issues.

25 The fact that WA's processes require custodial management's approval for the introduction and funding of a standard health management tool speaks volumes about the organisational status of health services in a Justice-managed situation. The response to the Discussion Paper highlighted this point by referring to the need of the Health Services Directorate to compete for funding *with the Department*: see note 11, above.

Many of these matters will overlap, with offenders having two or more health issues from these categories.

The service provider needs to develop and implement comprehensive policies in each of these areas. They are all areas of health that tie in with general community health services and which, accordingly, would benefit from being managed by a comprehensive health services provider – the Department of Health – rather than a marginal one – the Department of Corrective Services. Three areas will be highlighted for the purposes of this Draft Report: mental health issues; drug use; and Aboriginal health issues.

Mental health issues

Mental health problems include a range of psychological and/or psychiatric conditions that include major personality problems, substance abuse[26] and mental illness.[27] In terms of treatment, only mental illness conditions that are usually managed by a psychiatrist respond to medications.

Personality disorders cover a range of chronic, maladaptive behaviours that do not respond to medication and are notoriously difficult to treat. Prisoners experience very high rates of mental health problems, and it is often the severe personality disorders that prove the most difficult to manage in prison.

The Butler and Allnut[28] study conducted in 2003 in New South Wales found that:

- The prevalence of mental illness in the NSW correctional system is substantial and consistent with international findings.
- The twelve-month prevalence of mental health problems (including psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder, or neurasthenia) identified in the NSW inmate population was substantially higher than in the general community (74% vs. 22%).[29]
- Almost half of reception (46%) and over one-third (38%) of sentenced inmates had suffered a mental disorder (psychosis, affective disorder, or anxiety disorder) in the previous twelve months.
- Female prisoners had a higher prevalence of psychiatric disorder than male prisoners. Most of these women had been prescribed medications at some time during their imprisonment.

26 Drug dependency is listed in DSM-IV, but is not viewed as a mental illness in Australia. However, women with substance abuse problems have a high level of mental health co-morbidities; depression and anxiety disorders being most common.

27 Mental illnesses are classified in DSM-IV (a reference used in Australia and the U.S.) and include anxiety disorders, depression and psychosis. In Western Australia, mental illness is usually managed in conjunction with a consulting psychiatrist.

28 Butler, T and Allnut, S, *Mental Illness Among New South Wales' Prisoners.* (New South Wales: Corrections Health Service, 2003).

29 A comparable survey of the UK prison population found that 72 per cent of male and 70 per cent of female prisoners suffer from two or more mental health disorders. This range of prevalence is remarkably congruent across these populations in a similar context of de-institutionalisation of mental health patients.

The National Inquiry into the Human Rights of People with Mental Illness, otherwise known as the *Burdekin Report*, was conducted in 1993 and provides a benchmark against which the delivery of mental health services can be measured. The inquiry found serious inadequacies in the mental health treatment received by prisoners. Burdekin concluded that procedures for detecting and treating mental illness and disorder in the Australian criminal justice system were inadequate in all jurisdictions and that with the closure of the large mental health institutions, the prison system had de facto and inappropriately become the treatment centre for many mentally ill people.[30]

Burdekin found that the inadequacy of treatment available for mentally ill prisoners contributed to further criminal offending, longer incarceration and aggravation of their mental illness. For Aboriginal and Torres Strait Islander people, incarceration was particularly damaging, yet forensic mental health services were systematically failing to meet their needs.

Burdekin went on to recommend that corrective services departments should ensure that individuals detained in custody are appropriately assessed, all staff should have appropriate training in mental health issues and prisoners should be able to access adequate treatment by mental health professionals.

On the whole, things have not improved since Burdekin. *The Palmer Report*,[31] as recently as July 2005, highlighted the deficiencies in mental health diagnostic and treatment services in Immigration Detention Centres and the Queensland Department of Corrective Services, as well as the lack of integration between the Commonwealth Government arrangements and the provision of mental health services in South Australia. There is little debate that the custodial services, while acknowledging the extent of the problem, are not doing enough to address the needs of those prisoners with mental health problems.

The failure of the wider mental health system and, in particular, the lack of suitable forensic mental healthcare, has placed the burden on poorly resourced prisons. The 2005 Report of the Mental Health Council of Australia in conjunction with the Human Rights and Equal Opportunity Commission, *Not for Service: Experiences of Injustice and Despair in Mental Healthcare in Australia*,[32] documents profound failures throughout Australia in meeting the National Standards for Mental Health Services. These had been developed after the publication of the *Burdekin Report*, taking account of the United Nations *Principles for the Protection of People with Mental Illness and the Improvement of Mental Healthcare* (1991). Despite an improvement in per capita expenditure in recent years, Western Australia falls well short of meeting those standards.[33] Clearly, the State's capacity to deliver adequate mental health services into prisons and juvenile detention centres is fundamentally influenced by its overall capacity to deliver services to the general population. However, the offender population is certainly among the most needy, therefore the payoff may be relatively greater.

30 Burdekin, B, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness.* (Human Rights and Equal Opportunity Commission, 1993).

31 Palmer, M, *Report of an Inquiry into the Circumstances of the Detention of Cornelia Rau* (2005) <http://www.minister.immi.gov.au/media_releases/media05/palmer-report.pdf>

32 *Not for Service: Experiences of Injustice and Despair in Mental Healthcare in Australia*, (Canberra: Mental Health Council of Australia, 2005).

33 Ibid, pp. 584-668

The Social Systems and Evaluation (SSE)[34] study indicated that the rate of psychiatric disorder among prisoners was almost double that of the overall WA population. Other estimates, in particular the figures derived from the New South Wales 2003 analysis, would suggest that the disparity is far higher than this. In spite of this, psychiatric services have been found to be inadequate during prison inspections from this Office. It is not surprising that mental illness will be high in this population, given the higher levels of substance abuse, unemployment, poverty, childhood abuse and simply the experience of being detained within a prison environment. The retrospective study of ex-prisoners carried out by Hobbs et alia[35] confirms the extraordinary needs of this population.

The only specialist facility available for the treatment of mentally ill offenders is the Frankland Unit, at the Graylands Hospital complex. This is a 30-bed, high-security, forensic psychiatric in-patient service. The centre mainly provides for:

a) Accused persons referred from the courts for psychiatric assessment
b) Prisoners with a mental illness referred from prisons across the state
c) Patients unfit to plea due to reasons of insanity.

The prison system is a major source of admissions for the centre. In 2001/02 of a total 285 admissions, 73 were from the prison system; in 2002/03 the number of admissions from prisons increased to 95.[36] It is generally accepted by both Departments that the capacity of the Frankland Unit is not sufficient to cope with the need for prisoner services; there is a distinct element of musical chairs in the occupancy patterns, with one prisoner often being moved back to a prison to make way for another prisoner. In Victoria, the Thomas Embling Hospital has a capacity that is more than three times greater, in relation to a prison population that is virtually the same size as that in Western Australia.

The problem of untreatable severe personality disordered offenders – the other category that is prominent in prison populations – has recently attracted attention from the WA Minister for Health, who is also the Attorney General. A proposal for a Health-managed facility for such offenders is currently being considered at Government level. Interestingly, in the context of the principal recommendation of this Report, there has been no serious dispute that the health aspects of a health service for detained offenders must be run by a service provider whose business is health. This is such a simple and straightforward proposition that it is difficult to understand how it can be challenged.

Finally, the physical health status of psychiatric patients and people with mental health problems is markedly worse overall than that of the general population.[37] For example, excess

34 Cant, R, Downie, R and Mulholland, T, *Cohort Analysis of the Custodial Population for the Ministry of Justice* (Social Systems and Evaluation, 2000).
35 See note 24, above.
36 Information provided by the Frankland Unit.
37 Lawrence, D, Holman, D and Jablensky *A Duty to care: Preventable physical illness in people with mental health problems*. (Perth: Centre for Health Services Research in the Department of Public Health, 2001).

risk of ischaemic heart disease rather than, as previously assumed, excess risk of suicide is the leading killer of people with mental illness.[38] As such persons are vastly over-represented in the prisoner population, this constitutes an additional reason for ensuring that the health services delivered in a prison setting are capable of meeting community health standards in ways appropriate to population needs.

Prior drug use by offenders and prison-based pharmacotherapy programs

It is by now a truism that drug use is one of the most prevalent risk factors contributing to offending and re-offending.[39] The Drug Use Careers of Offenders Study,[40] which was conducted in 2000, surveyed the drug use histories of adult sentenced male prisoners in Western Australia. Results showed that:

- 80 per cent are regular illicit drug users
- 50 per cent reported a high level of drug dependence
- 83 per cent had used cannabis
- 60.9 per cent had used amphetamines
- 46.4 per cent had used heroin at least once
- 23.6 per cent indicated that they used heroin regularly
- 34.3 per cent indicated that they used amphetamines regularly.

This study, along with the regular Drug Use Monitoring in Australia (DUMA) reports produced by the Australian Institute of Criminology, shows that drug use in the offender population is highly prevalent.

Prisoners with drug use problems have health needs stemming directly from their drug use, eg. withdrawal, and also have needs relating to their previous lifestyles and high levels of mental health co-morbidity. It is estimated that up to 80 per cent of people experiencing drug use problems also have a co-occurring mental health problem,[41] most commonly depression and anxiety. Poor nutrition, lack of dental care and lifestyle also contribute to poor health among problematic drug users. The lack of access to clean injecting equipment for injecting drug users can increase the risk of contracting a range of blood-borne viruses, including hepatitis C and HIV.

To tackle the problem of drug use by offenders, the Department has developed a Drug Plan that includes strategies to address the supply and demand for drugs in prisons and strategies such as targeted education programs to reduce the harm associated with drug use.

38 Lawrence, D, Holman, D, Jablensky A and Hobbs, M 'Death rate from ischaemic heart disease in Western Australian psychiatric patients 1980-1998' (2003) *182 British Journal of Psychiatry 31-36.*
39 Department of Justice *Managing Drugs in Prison* <www.justice.wa.gov.au>
40 Ibid.
41 Scottish Executive *Mind the gaps: meeting the needs of people with co-occurring substance misuse and mental health problems* (2003).

Key elements of the Justice Drug Plan that relate to the delivery of health services include:

- Introducing a comprehensive opiate replacement pharmacotherapy program
- Expanding treatment programs for high-risk offenders
- Introducing harm reduction measures to reduce the prevalence of blood-borne communicable diseases.

Opiate replacement pharmacotherapy is the substitution of a prescribed narcotic (most commonly methadone) for an illicit opiate (usually heroin).[42] Methadone and Subutex are only indicated for people with a history of problematic opiate use. Methadone treatment represents the 'gold standard' in the treatment of heroin dependency and compared to other treatments, including counselling and residential programs, methadone has good compliance. Successful outcomes are directly related to the length of time on the program. It is important to note that methadone is a 'maintenance drug' and best outcomes are achieved for those who are prepared to stay on the program long enough to stabilise their lifestyle. In a prison environment being on methadone reduces the compulsion to use illicit opiates and reduces the risk of needle sharing.

For many years the Department had resisted the introduction of a full-scale methadone program, and access had been limited to pregnant women and people who were HIV positive. Fears of diversion and standover contributed to the Department's and staff reluctance to support a prison-based program. In February 2003, the Attorney General and Minister for Justice, Hon. Jim McGinty, led a Drugs Roundtable that brought together experts from around Australia on drugs and drug management trends in the community. Following the roundtable a commitment was made to initiate a comprehensive opiate replacement pharmacotherapies program with a directive that the introduction of the program be prioritised.

In essence, the Health Services were given a six-month period to develop the program, train staff and implement treatment. This implementation schedule was extremely rapid and, given the complexity of the new programs and the need to acculturate a 'suspicious' staff, presented a huge challenge to the health services team.

The pressure to introduce the program limited the opportunities for widespread consultation, and to this day there exists a feeling among both nursing and custodial staff that the pharmacotherapy program was 'thrust' onto them.[43] Some initial training was provided: this consisted of three days for nurse managers and one additional staff member. Reports indicate that although nursing staff were well aware of the need for this initiative, their main concern was the lack of resources and time with which this was to be implemented.

42 Replacement pharmacotherapies are available for other drug types such as alcohol; however, there is no replacement pharmacotherapy for amphetamines.

43 Office of the Inspector of Custodial Services (OICS) *Report of an Announced Inspection of Casuarina Prison*, Report No. 28 (June 2005) [6.4–6.9]. This report notes in detail the resentment and misunderstanding that the introduction of these programs had caused, particularly amongst custodial and vocational support staff, at Casuarina Prison.

Early plans for the program envisaged that all prisoners prescribed an opiate replacement pharmacotherapy would also be required to undertake a counselling program. Initial funding for the program was relatively generous; however, the available budget was soon used up on the delivery of the pharmacotherapies with little remaining for the development of the counselling programs. The concept of a holistic program that was supported by a counselling component was allowed to fade away. There remains a feeling among staff that the integrity of the program was lost and that without the counselling component it does not offer the best possible outcomes for the participants.

The program commenced on 14 September 2003 at both Bandyup and Hakea Prisons using two drugs, methadone and buprenorphine (Subutex).[44] The Prison Addiction Service Treatment (PAST) was formed, and a Project Manager PAST position was located in Head Office. This position managed the PAST coordinator whose responsibilities straddled Head Office and the prisons. Participation rates grew quickly. In December 2003 there were 128 patients in treatment; by June 2004 numbers had grown to 209. Overall, the numbers of prisoners receiving pharmacotherapies between August and October 2004 had stabilized and by this date the number of prisoners on pharmacotherapies in public prisons represented 7.8 per cent of the total prison population.[45] Interestingly, female prisoners were 2.5 to 3 times more likely to be on pharmacotherapies than male prisoners.[46] By early 2006, the program was available in most prisons in the state with about 300 prisoners involved at any given time.

The Crime Research Centre at the University of Western Australia (CRC) commenced evaluation of this program in April 2004. Since then it has released three progress reports on its findings as well a document on best practice principles for prison-based pharmacotherapy programs.[47] The 3rd Progress Report (December 2004) highlighted the following problems:

- Lack of direction

  There was a reactive rather than proactive approach to decision making. There had been a high turnover of staff in management and coordination roles, with the latter being unfilled for approximately six weeks. The CRC noted that the failure to have processes and procedures clearly set out and documented has resulted in problems for all staff, both health and custodial. This approach has resulted in inconsistencies across prisons.

- Clinical Care

  Staff had concerns that the assessment process was 'suspect' and any prisoners could ask to be placed on the program, thereby obtaining 'free drugs.' Non-PAST staff within health clinics wanted a more transparent assessment process and properly evidenced and documented decisions based upon standardised practice.

44 Continuing concerns about the diversion of Subutex has virtually meant that prisoners are no longer offered Subutex as a treatment option. Subutex is a sub-lingual preparation and therefore easier to secrete than methadone which is oral. Drug detection dogs have not been trained to sniff Subutex.

45 Crime Research Centre: University of Western Australia *Evaluation of the implementation of the prison pharmacotherapy treatment service program: 3rd Progress Report prepared for the Department of Justice* (2004) 8.

46 Ibid.

47 Roberts, L, and Indermaur, D. *Best Practice Principles for Prison-Based Pharmacotherapy Programs* (Nedlands: Crime Research Centre, University of Western Australia, 2004).

- Confused accountability lines

  The PAST nurse's line of management differed from that of other nursing staff within health clinics. Whilst staff at some prisons wanted the PAST nurse to come under the management of the Nurse Manager, Head Office clearly wanted this position to be managed separately so as to ensure that PAST nurses would not be assigned other general nursing duties.

- Lack of resources

  Both nursing staff and doctors at sites told of the increase in patients due to the introduction of this program. The CRC reported that prescribing doctors felt they spent less time with general patients whilst at Acacia and Hakea, PAST nurses were struggling to cope with the workload.[48] Staff turnover has been high with the loss of significant positions in head office as well as on-site PAST nursing staff. The demand on prison officer workload has also increased, given the need for monitoring and supervision of prisoners who are taking the drugs. There was apparently no budget allocation for the work provided by custodial staff.

- Staff training

  The new practice of prescribing drug users such substances as methadone and buprenorphine in prison environments would quite naturally be met with concern. As with any new initiative to be introduced in any environment, the training and education of key staff is vital. This is no less the case in this situation – in fact it is more so. As confirmed within the CRC Report, staff across the board emphasised the need for better training the program for developments.

  Given the above factors, it should therefore come as no surprise that this poor planning and rushed implementation of such an important initiative resulted in problems for prisoners, prison management, offender programs and prisoner health services. [49] In its response to the Discussion Paper, the Drug and Alcohol Authority appeared to confirm these problems.

  Continuation of treatment on release into the community is critical for reducing the risk of reoffending and ensuring success. A partnership has been developed between Health Services and Next Step who assume responsibility for coordinating treatment after release.[50] Next Step doctors also provide sessions within the prisons. This is a positive initiative as it provides opportunity for consultation with existing prescribers[51] and provides greater consistency in care.

48 Roberts, L, and Indermaur, D. *Best Practice Principles for Prison-Based Pharmacotherapy Programs* (Nedlands: Crime Research Centre, University of Western Australia, 2004) 13.

49 See note 43 above.

50 'Next Step' is the clinical branch of the Drug and Alcohol Office and is funded through the Department of Health.

51 Medical officers wishing to become prescribers of opiate replacement pharmacotherapies must undertake specialist training and be authorised by the Department of Health. Not all medical officers working within the prison system are authorised prescribers.

The success of this program from the point of view of recidivism has not yet been evaluated. Nevertheless, it is clearly an important initiative. The involvement of the Health Department has been recognised by Corrective Services – yet it is neither running it nor not running it. Clearly, as a medical program of the sort that Health runs in the community either directly or through NGOs, it would benefit from being holistically managed and controlled by the Health Department.

Aboriginal Prisoner Health Issues

At any given time Aboriginal prisoners represent about 40 per cent of the adult and 80 per cent of the juvenile custodial populations. These disparities, in comparison to non-Aboriginal prisoners and detainees, are the worst in Australia and amount to a badge of shame for the Western Australian criminal justice system. Paradoxically, however, they do represent a rare window of opportunity to assess and intervene in the health status of a segment of the Australian population, which is disadvantaged in terms of morbidity and mortality to the point of being almost Third World citizens. The current socio-political context of Aboriginal health issues in Australia has been discussed in Chapter 3, above.

In New South Wales, the data from the *2001 Inmate Health Survey*[52] found that the health issues for Aboriginal prisoners included the following:

- Between 78 per cent and 95 per cent reported chronic diseases such as diabetes, cardiac disease, respiratory and early renal disease
- 46 per cent of receptions had suffered a mental health disorder
- 40 per cent to 64 per cent had hepatitis C
- 64 per cent to 74 per cent used drugs regularly
- 80 per cent were smokers, compared to 20 per cent in the community
- There were high levels of alcohol abuse
- 57 per cent to 64 per cent reported that their last dental care took place in prison.

Such health issues are exacerbated by poor living conditions, poverty and alcohol abuse. The increasing use of drugs amongst Aboriginals is also adding to the already complex array of conditions. [53]

Numerous inspections by this Office have confirmed the poor health status of Aboriginal prisoners, even though in the absence of a comprehensive health status survey it is not possible to put precise figures on these matters. These inspections have also identified a rather patchy pattern of co-ordination between Corrective Services Health Services Directorate and the various Aboriginal Medical Services throughout the State, as well as almost complete failure of Corrective Services to employ Aboriginal Health Workers. The study by Hobbs *et alia* stated:

52 Butler, T and Milner, L *The 2001 New South Wales Inmate Health Survey*. (New South Wales: Corrections Health Service) 8-9.

53 Gray D, Saggers S, Atkinson D, Carter M, Loxley W, Haywood D. *The Harm Reduction Needs of Aboriginal Injecting Drug Users,* (Perth: National Drug Research Institute, 2002).

> Aboriginal prisoners are particularly at risk of death and hospitalisation from a wide range of acute and chronic health disorders. In addition to reducing social disadvantage that leads to chronic diseases, the health problems of Aboriginal prisoners need to be addressed through culturally appropriate health services. Wherever possible this should involve the participation of Aboriginal Medical Services.

Unfortunately, this is another absolutely key area of public health where a marginalised health service provider seems to be unable to overcome some of the barriers in the way of catering fully for some of its most needy patients. It is difficult to see any good reason why this aspect of health service provision in the Western Australian community should not be integrated with the general arrangements for the delivery of health services in the state.

Chapter 9

THE ROLE OF THE DEPARTMENT OF HEALTH AND ITS RELATIONSHIP WITH THE HEALTH SERVICES DIRECTORATE OF CORRECTIVE SERVICES

The longstanding 'prison medical parades/medical orderlies' model that characterised the first 150 years of imprisonment in this state started to break down in about 1980. *The Prisons Act 1981* created a system of responsible 'medical officers' and was drafted in terms that predicated a duty of care. The inexorable logic of this was that greater input into processes, priorities and appropriate treatments was required from the medical profession generally.

Around 1993/94 a Joint Justice/Health Interdepartmental Council (JJ/HIC) had been established. This council reported to the Attorney General and the Minister of Health on the management and functioning of prison health services. In 2000, this changed to become the Offender Health Joint Executive (OHJE), meeting on a monthly basis and comprising senior members of both departments. A Clinical Advisory Committee was also established at this time; its constitution comprised, as its name suggested, persons much more concerned with day-to-day treatment issues and regimes.

It should be clarified that by this time nursing staff at all prisons, except Casuarina and Hakea, were employed under the ANF award, and were benefiting from better pay rates than those available to 'hospital officers' who belonged to the Western Australian Prison Officers Union (WAPOU).[54] In December 2002, nurses at these two prisons joined the ANF, unifying the nursing division and providing some scope for a career structure for nurses. It should, perhaps, be noted at this stage that employment by the Department of Health under apparently equivalent conditions of the ANF Award is considerably more beneficial than employment by the Department of Corrective Services; this paradox revolves around the fact that Health Department personnel are permitted to salary-package to a far greater extent than Corrective Services personnel. It should also be spelt out that the career structure for Corrective Services Health Services nurses is far more restricted than that for Health Department nurses.

The provision of specialist health services, particularly dental and psychiatric, was also difficult. Many psychiatrists in earlier years would not work within the prison system. Psychiatric services were either provided by the Department of Health (DOH), in the form of visiting psychiatrists, or by the State Forensic Mental Health Service through the secure Frankland Unit at Graylands Hospital.

Mental health services, short of those requiring medication, were also provided by the Forensic Case Management Team (FCMT), a multi-disciplinary team of allied health professionals from the disciplines of social work, psychology and occupational therapy, and prisoner support officers. The number and combination of staff varied from prison to prison, with the majority located in the metropolitan prisons. FCMT staff worked closely with other health professionals in order to provide mental health services to prisoners. FCMT, now known as Prison Counselling Service (PCS), was under the management of Prison Health Services up until the latter part of 2001/2002. However, at that time the decision was made to transfer the PCS function to the Offender Services and Sentence Management Directorate. It would seem that OSSM inherited a budget that was insufficient to maintain an adequate counselling service to prisoners.[55]

54 However, hospital officers fell within WAPOU arrangements for overtime, shift loadings and sick leave entitlements, which were generally more beneficial.

55 Department of Justice, *Prison Counselling Service Funding Requirements* (undated).

THE ROLE OF THE DEPARTMENT OF HEALTH AND ITS RELATIONSHIP WITH THE HEALTH SERVICES DIRECTORATE OF CORRECTIVE SERVICES

The Health Services Directorate was formed in 1996. It set out to be a patient-focused multidisciplinary team that also initially included the Forensic Case Management Team (FCMT). The current Director of Health Services was appointed in June 2002. The ultimate line responsibility for health services was lodged at that time with the Executive Director, Prisons Division. After a brief period reporting to an executive who, in turn, reported to the Director General, Health Services once more came under the direct responsibility of the Executive Director of Prisons.

In 2004, the Director of Health Services reviewed the strategic direction of the service. Emphasis was placed upon (among other things) the name 'Health Services' with a desire to move away from the old 'Prison Health Service.' This was intended to reflect more accurately the philosophical intent of the Directorate. The mission of this service was to see 'patients as our business.' This message was promoted to staff during strategic planning meetings held within Health Services.

The review of the strategic direction of Health Services provided an opportunity to identify the key attributes that were essential when considering the health of prisoners. Firstly, Health Services recognised the need for a **Justice-healthcare continuum** – a service that goes across all stages, targeting health needs through early access and intervention. Secondly, they recognised that a greater understanding is required of the **social determinants** of health – such things as housing, employment and life history. When understood and taken into account, these factors can impact upon the health of individuals. Finally, there was recognition that there should be a focus on **illness prevention**. Considerable amounts of time and resources are spent on reactive issues, as opposed to being more proactive and targeting the causes of illness – for example, smoking, poor nutrition, alcohol and lack of physical activity. [56]

In 1998, the matter of contestability was first discussed at the Joint Justice and Health Interdepartmental Council (JJ/HIC), and the Department decided to test the market for its health services in order to achieve an integrated service in terms of both the range of services and how these were distributed across the state. As previously mentioned this initiative petered out. The Project Steering Committee gave consideration to recommendations made by the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) in terms of prison health services being controlled by a body external to Justice (a view, it will be recalled, still current in some of the responses to the Discussion Paper). However, given that Prison Health Services were to remain within the Department of Justice, it was merely suggested that an advisory body be established to oversee the delivery and management of health services to prisoners at a strategic level. Shortly thereafter, the Offender Health Joint Executive and the Clinical Advisory Committee came into existence.

During 2001, the issue of prisoner health remained a priority, and the Attorney General voiced his view in the *West Australian* that prisoners should not have to endure sub-standard healthcare.[57] Discussions between the Attorney General, the Department of Justice, the

56 The above philosophy is now encapsulated in the July 2005 document, Department of Health, *Strategic Intent 2005-2010.*

57 Butler, J, 'Prison Health Boost on the Agenda' *The West Australian,* 12 April 2001, 27.

Department of Health and the Inspector of Custodial Services took place about how to best meet the health needs of prisoners. The outcome was that the Inspector suggested that a Ministerial Advisory Committee on Prisoner Health Services be established in order to advise the Minister for Justice and the Minister for Health.

The role of the proposed committee was to be strategic, advising the ministers as required. A meeting between the Attorney General and the Inspector, in December 2001, discussed this proposed committee and the related functions. The basic flaw in arrangements was that the Director of Prisoner Health Services continued to report to the Executive Director of Prisons. However, it was thought that this new arrangement might well be a temporary staging post en route to transferring the function to the Health Department, depending on how service provision panned out. [58]

The Attorney General, in March 2002, requested that a new body, the Offender Health Council (OHC), be established, consisting of the CEOs and other high-level members of each Department, as well as two independent members: the Inspector of Custodial Services and the Director of the Office of Health Review. This concept was derived from the previously discussed Ministerial Advisory Committee. The first meeting of the OHC was held in June 2002. It was acknowledged at this meeting that both Departments should work together cooperatively. Operational matters would remain the responsibility of the OHJE, with matters of high-level policy and strategy coming before the OHC.

At this inaugural meeting of the OHC, four issues were raised[59] and the Council agreed that they should be given strategic priority.[60] These matters were:

1. The need for a comprehensive study of the health status of offenders.
2. An evaluation of Aboriginal health policy.
3. Enhanced mental health services.
4. Structural problems associated with the provision of health services within a custodial environment.

During the course of this first meeting a fifth additional issue, the role of alcohol and drugs in the health of offenders, was identified as requiring strategic priority.

A strategic planning workshop, held in September 2002, decided that the organisational structures for the provision of health services to offenders should remain unchanged. The minutes of the OHC meeting held later the same month note that the DOH 'was not in favour of a transfer at this time, but strongly committed to the partnership approach.' The Offender Health Council was not given an opportunity to debate the merits of the issue, but simply endorsed the recommendation.[61]

58 Harding, R, meeting with the Hon. Jim McGinty (18 December 2001). It is acknowledged that these notes do not necessarily reflect the minister's own views.
59 The Inspector of Custodial Services raised these four issues, based upon the ten prison inspections that had been carried out to that point.
60 Offender Health Council (OHC) minutes of meeting, Department of Health (4 June 2002).
61 This Office has never assented to this proposition.

The two Departments then affirmed their view 'that the development of improved services for offenders is most likely to be achieved by a partnership arrangement.'[62] The ministers for both Justice and Health endorsed this position. A draft memorandum of understanding (MOU) was discussed at the Offender Health Council meeting of 25 March 2003 and on 16 April 2004, both ministers signed the MOU. It expired on 30 June 2005 and has subsequently been renewed for a further three years.

The question arises: how does this MOU actually work? What happens on the ground? The answer appears to be that **the Health Department, despite the existence of the MOU, regards prisoner health as a low priority, readily dispensable when other issues are more immediately pressing.** Examples relate to pathology services, dental care and mental health services.

For many years pathology services had been provided gratis to the Department of Justice. However, at the Offender Health Council meeting of 16 November 2004, it emerged that arrangements were being negotiated to transfer the notional cost of pathology services to Justice on the basis that these services would thereafter be purchased from Health at full cost as required. This is a deal that, because of the rapidly increasing cost of such services, is in reality a way of reducing Health's partnered contribution to prisoner health services, thus squeezing the available budget of the Health Services Directorate.

Another example is the situation with dental services, which ceased in late 2004 due to the lack of dentists available in the public system. The Offender Health Council meeting of April 2005, endorsed a recommendation that Health should make available to Justice the funds previously allocated to dental services to enable Justice to try to buy in private dental services. As it turned out, only one full-time equivalent (FTE) item had been allocated to this service, even though in practice approximately three FTEs had been involved when dental services were at their optimum level. So to 'repatriate' the equivalent funds to Justice was in reality to diminish the service even more. In this regard, there is a precise parallel with the proposed arrangements with pathology services, described above. Although the MOU was supposed to protect service provision to Corrective Services, prisons are in practice the first to lose services. Waiting lists now have increased to some 18 months. If the Department of Health were statutorily and administratively the core service provider, it would not be possible for it to so readily opt out of responsibility.

The situation with mental health services is somewhat different. It should be put unambiguously on the record that the persons responsible for managing the statewide Forensic Psychiatry Service endeavour to deliver services to Corrective Services to the best of their ability, given the overall inadequacy of psychiatric services in the community as a whole – a point emphasised by the Mental Health Council Report (2005) referred to earlier. Ambivalence seems to find expression at a different level.

62 *Memorandum of Understanding*, Department of Health and Department of Justice (24 October 2003).

At the first OHC meeting in 2002, a strategy to provide a comprehensive mental health service for 'at risk' prisoners was proposed. One of the requests was for the creation of an Intermediate Care Unit (ICU) of between 20-36 beds at Hakea Prison and a similar six-bed unit at Bandyup Prison. The idea was that persons with chronic psychiatric disorders could be cared for in an environment other than the general prison. Also, the existence of such units would enable some prisoners who had been transferred to the Frankland Unit to be returned to prison a little earlier in their treatment, thus freeing up a bed at that unit for another acute patient. However, this proposal was not successful in attracting funding.

The OHJE recommended a number of strategic priorities to the Offender Health Council at the next meeting on 26 September 2002. Recommendation 3 was that: 'the OHC to determine what funding should be sought in 2003/04 by Health and by Justice for improvement of mental health services for offenders.'

The minutes note that the required improvements in mental health services for offenders would have substantial resource implications. This was not surprising given the plethora of research about rates of mental illness in offender populations and the impact of prison upon mental illness. The initiative gained 'in principle' approval, but would require review and development for the 2003/04 budget round. The proposals involved a DOJ component of $1,212,000 for the first year and $2,321,000 in subsequent years. DOJ management supported this; however, the bid failed to attract funding. By any standard of health service provision, this is a trivial amount.

Once more, however, the Government failed to support this approach to dealing with the mental health of prisoners. It later became clear that Health was not prepared to give it support equal to its own core initiatives, so that in effect the bid was a divided one. The way governance works, a divided bid is doomed, as the parties well understood.

A problem is that a health initiative coming primarily from Justice is, in bureaucratic terms, an oddity. The Health Department, being peripheral to the responsibility for service delivery, has not unambiguously supported funding bids purportedly made in partnership. What should be core business – public health interventions with a cohort of patients whose health status is far below average – is not perceived that way within the Health bureaucracy. Subsequently, the Department of Health has received Government support in excess of $20 million for a mental health strategy submitted on its own account, but this did not make mention of provision of services to prisoners.

There are, of course, many areas where the relationship between the two Departments is less unequal than in the examples cited above. Nevertheless, the observation of the Inspector, both specifically in the course of this thematic review and generally, after 30 or so inspections of the health services in prisons and juvenile detention centres is that, Corrective Services is very much a second class citizen as far as Health is concerned. As long as Health is enabled by the bureaucratic arrangements to continue to regard offender health issues as primarily 'somebody else's business,' this is unlikely to change.

Chapter 10

ASPECTS OF THE HEALTH SERVICES SUPPLIED BY THE CORRECTIVE SERVICES HEALTH SERVICES DIRECTORATE UNDER THE PRESENT ARRANGEMENTS

The Discussion Paper traversed the question of the quality of health services supplied at the various health centres in great detail: see pages 50-89. Reliance was placed on previous inspections, documentation supplied to the Inspector by the Health Services Directorate, interviews, discussion, surveys of staff and patients and an intensive fieldwork phase at five prisons conducted with the assistance of four medically-qualified consultants with wide experience in this area.

It is not proposed to detail all of these findings in this Draft Report; they can be found in Appendix 2 on the attached CD. Problems have over the years been endemic, though as one would expect, it is a mixed picture – good in parts, indifferent in others and below an acceptable standard elsewhere. However, it is a changing picture, in terms of management, staffing, range of services and infrastructure. On the whole, that change has been for the better, perhaps epitomised by the fact that at the second attempt the Service succeeded in gaining accreditation from the Australian Council of Health Services.

It is important to acknowledge the progress that has been made, so that subsequent comments do not seem to be niggardly or unduly critical. However, the nature of a review such as this is that it needs to identify issues that have a bearing on how a service could better be delivered and, in turn, whether an alternative provider might be better placed to deliver that service. Themes that emerged at one or more Health Centres included the following:

- Inadequate dental care, with long waiting lists
- An increase in paperwork that was, in the view of nursing staff, getting in the way of service provision to no good purpose
- An inability of nursing staff to affect diet provision, particularly in the Aboriginal prisons in relation to diabetic patients
- Inadequate resources to undertake health promotion in more than a tokenistic way
- Poor or non-existent psychiatric services
- Inadequate links to community services, particularly for Aboriginal prisoners through the various Aboriginal Medical Services
- Fragile arrangements and inadequate training for the delivery of pharmacotherapy services
- Frequent cancellation of external medical consultations because of the unavailability of transport through the contracted service run by AIMS
- Concern about personal safety of staff, yet paradoxically concern about some medically inappropriate security measures imposed on patients by way of restraints
- On-call arrangements that require first resort out-of-hours to a Perth-based locum service for verbal advice
- Generally, concern about workloads as the prison population has continued to increase.

Broader issues to be highlighted are as follows:

- The Service is fragmented and does not amount to a total system in which each component is used in ways that complement other components
- Security concerns and custodial attitudes prejudice some service delivery, so that prisoners are often treated first and foremost as prisoners and less as patients
- There are staffing problems as to recruitment, relations with management, training opportunities and career paths.

Fragmented service

During the week of 26 July 2004 the Inspection Team visited each of the five metropolitan prison health centres (Acacia, Bandyup, Boronia, Casuarina and Hakea) to review practice, inspect premises, meet available staff and assess the provision of services. The basis for selecting these prisons for intensive inspection was, above all, to ascertain whether and to what extent their operations were complementary to each other.

For example, in the case of the three male prisons, was the Casuarina Infirmary serving the needs of the prison population as a whole? In the case of Acacia, was the Aged Care Unit functioning as a statewide facility? Across the three prisons, were Crisis Care Units being utilised in ways that facilitated the management of at-risk prisoners generally or were they merely local in their operations? Similarly, with the two women's prisons, were the health regimes tied in to each other so that the medical needs of a Bandyup prisoner could be met upon her transfer to Boronia? In other words, was the health system being managed in such a way that it did not constitute a barrier to meeting the pre-release needs of women prisoners?

Meetings also took place with staff at the Frankland Centre, Next Step and with some Department of Justice Health Service staff and senior management. On 14 and 15 September 2004 additional meetings took place with the Director of Health Services and Population Health representatives from the Department of Health as a follow-up to the written debrief that had been sent following the site visits.

Of course, inspecting these premises from a whole-of-system point of view could not be done without also looking at the strengths and weaknesses of the individual health centres. These findings are fully set out in the Discussion Paper.

The summary position of this series of metropolitan site visits, carried out intensively over a short period, revealed that the services available for male prisoners **are not integrated as a health service.** What is available largely depends upon where the prisoner is situated at any given time and that is, in turn, driven by custodial needs and/or convenience. Some facilities are barely utilised – for example, Crisis Care at Acacia – and others partially utilised for purposes that were not intended – for example, the Geriatric Unit at Acacia which houses protection prisoners who are not geriatric, as well as those who genuinely need aged care. The potential of others – for example, the secondary care infirmary at Casuarina – has never been fulfilled or developed; it has been used as much for aged care as for secondary nursing

care. The overall impression is very much that Health Services manage as best they can in a somewhat *ad hoc* manner, with their main focus on primary care and, increasingly, opiate replacement pharmacotherapy.

In relation to female prisoners, there is a need to develop a Women's Healthcare Strategy to reflect a women-centred approach to their health needs. Although there have been improvements in the delivery of services at Bandyup, deficits remain. The links between the two main women's prisons are better integrated than in the case of the male prisons, and the services at Boronia resemble as closely as is attainable an equivalent community service.

Security concerns and custodial attitudes

From the very inception of this Office, the Inspector has been concerned about the way in which security issues and custodial attitudes have impinged upon the delivery of health services in a timely and dignified way. Despite the stated objective of Health Services to provide people in custody with access to health services equivalent to what the general public receives, it is evident in some prisons that custodial restrictions impact upon this standard. Although 71 per cent of Health Services staff responded to our survey that they felt they have adequate access to prisoners in order to perform their duties, many also claim, as did prisoners, that lengthy delays are experienced because of security reasons. This seemed most evident at Bandyup, Hakea, Roebourne and Casuarina prisons, although it was not restricted to these establishments.

The Director of Health Services raised access as a serious issue impacting upon health service delivery. The Department is still somewhat under-staffed in terms of custodial officers (and indeed across the board). At Casuarina in particular, this restricts prisoner movement in order to access health services. It would seem that security issues and limitations on movement restrict access to appointments and cause backlogs in the system. Lengthy lockdowns over lunch (90 minutes) contribute to this problem; this can be exacerbated when officers are taken from the health clinic to carry out other duties. Medical staff are consequently only able to access prisoners for 90 minutes in the afternoon. Similar constraints were also observed at Roebourne Prison. Recent attempts to get dentists into this prison to deal with the increasing demand for this service were met with unhelpful responses from prison management in the sense that flexibility in staffing arrangements so as to facilitate movements to and from the dental clinic could not readily be achieved. [63]

The physical layout at Eastern Goldfields Regional Prison (EGRP) is such that security gates must be opened for prisoners to gain access to the Health Centre. [64] Prisoners at EGRP reported that staff, frequently, make them wait unnecessarily for security gates to be opened – though it is no less likely that these delays are due to general staff shortages.

63 Information received from the Director of Health Services.

64 A second clinic has been established in the maximum section and this has alleviated some of the need for prisoners to be escorted to the other health centre. Prisoners in the minimum male section and the female section still have to go through a gate to get to the centre.

Nurse access to prisoner-patients in the Casuarina Infirmary is restricted during lunch lock-down. Nurses do not have keys to access cells during this period or during the night. During this time both the officer on duty and the nurse must wait for an officer (in another area of the prison) to attend the health centre to enable access to cells. At Casuarina we witnessed a nurse having to wait for access to a cell over lunch to assist a prisoner who had fallen over whilst showering. Staff at Casuarina also stated that they were unable to easily access two patients then in the Infirmary who required turning during the night. Staff admitted that, in the community, these patients would be turned every 3-4 hours, which is currently not happening. The security risks of such frail and infirm patients are questionable.

Working in a prison can require staff to have dual responsibilities – to their patients and to the authority that employs them. The perception that health services staff have of the constraints upon their role is important. In this regard, staff surveys revealed that 32 per cent of the staff that responded, stated that they have been discouraged from providing the most appropriate medical treatment to patients, and 33 per cent claimed that a decision they had made about the best form of treatment had been overruled. Also, three medical officers claimed that their decisions as to the best form of treatment had been overruled and discouraged. Some staff claimed that senior officers, the Assistant Superintendent Prisoner Management (ASPM), the superintendent and custodial officers had all made such rulings. Whilst the formal documentation in no way supports such assertions, it seems that the informal culture is not as clear-cut.

The obverse of this can sometimes be seen in custodial staff making medical decisions. An early example known to the Inspector related to night-time incidents at Hakea. Prisoner alarm calls went to the control room, and the duty officer in effect was required to make a triage decision as to whether to pass this on to the duty nurse. Similarly, at the 2005 inspection of the Eastern Goldfields Regional Prison, we became aware of an incident where an epileptic prisoner fitted during the night and the duty senior officer made the decision to leave him to recover spontaneously for the remainder of the night, rather than call out a nurse or medical officer. The next morning he fitted again more seriously and had to be sent by ambulance to hospital. A final example relates to dental triage at Acacia Prison. This is, in effect, carried out by the custodial officers who manage access to the health centre; the criterion seems to be the apparent urgency and veracity of the potential patient's condition as it emerges from his verbal description.

These points are not made as criticisms of the custodial staff. They are doing their best in a context where they have become acculturated to the notion that such matters are part of their own responsibility.

Health Services, partly from lack of funding and partly because they have not strongly enough challenged the assumption that such processes are good enough, have contributed to this by steadily cutting back night-time coverage or even on-call nursing arrangements. At Greenough, for example, we encountered a situation where an unconscious prisoner with a blood alcohol level so high as to constitute a death risk was not seen, nor his condition managed, by anyone with medical knowledge. The reason given was that the cessation of

on-call medical services at regional prisons would save $600,000 per annum. A telephone consultation service with an on-call doctor in Perth does not really fill this gap. It hardly needs pointing out that a single death in circumstances that would constitute breach of a duty of care would wipe out these supposed savings.

We were also informed that in some cases the Director of Health Services had also overruled decisions made by medical staff. Of course, as the ultimate authority for utilisation of resources and broad policy, implementation rests at his level. This is not necessarily an adverse criticism. Nearly 46 per cent responded that prison budgets, policy and management restrict health staff in their ability to exercise clinical judgement. Over a third of those who responded felt that such restrictions impacted upon their relationships with prisoners. Approximately a quarter felt that management, of both custodial services and health services have, at times, been reluctant to support the referral of a prisoner to hospital for medical treatment.

Security concerns were further highlighted from responses on surveys, which indicated that 13 per cent of staff acknowledged that they are aware of cases when medication has been withheld as a management tool. The following comments epitomised this concern: 'Occasionally methadone will be held back' and 'Security concerns often determine the regularity of medication provision.'

Although not common, six per cent claimed that they had experienced conflict in their role because they had been instructed to do certain custodial tasks – for example, searches and restraints. In this Office's first inspection report on Eastern Goldfields Regional Prison, reference was made to the absolute inappropriateness of asking female nursing staff to participate in strip searches of female prisoners.[65] As recently as the 2005 inspection, this matter had still not been absolutely clarified and resolved.

Staffing issues

Staff survey responses strongly indicated that staffing numbers were low and a need existed for more nursing staff, general practitioner sessions and psychiatric sessions. Specifically, 60 per cent considered there was a need for more nursing staff; 67 per cent thought that there were insufficient mental health nurses; 55 per cent considered that psychiatric sessions were insufficient, and 62 per cent thought that there was insufficient attention paid to the need for Aboriginal staff in the Health Services Directorate. As a consequence, the available services were patchy. Examples included:

- Reduction of night nursing staff at Casuarina to one, so that the infirmary had to be left unattended if there was a medical incident in the main body of the prison as had happened on several occasions
- Inability to engage a local doctor for Bunbury Prison, leading to the necessity of a doctor driving down weekly from the metropolitan area, with the consequence that there were occasional late cancellations of the doctor's sessions. In one case,

65 OICS *Report of an Unannounced Inspection of Eastern Goldfields Regional Prison*, Report No. 4 (November 2001) [3.31].

this resulted in a carryover of 26 appointments for a week and the creation of a considerable amount of stress amongst patients

- Staff at Wooroloo, Roebourne and Karnet reported there had been no psychiatric services for an eight-week period while the psychiatrist was on annual leave. No back-up was put in place
- Cancellation of local on-call arrangements in regional prisons and the substitution of a telephone service to a Perth-based medical practitioner. This was widely agreed to be unsatisfactory and to create additional risk.

The education and training of staff varies considerably across all sites. Mandatory training is now provided by Health Services and covers such areas as 'at risk' assessments, security, and blood-borne viruses. Some staff reported that they had only just attended this training despite being employed for 18 months. An estimated 40 per cent of staff did not feel confident in their skills to deal with mental health issues, and 65 per cent reported that they had received no training on Aboriginal health issues. These are unacceptable deficiencies, given the profile of the prisoner-patient population in Western Australia.

Such in-service training as is available is for the most part not cross-disciplinary, so that the benefits of different health perspectives are not gained by staff. Just over 35 per cent of staff claimed that they are not encouraged to attend professional or personal development. Staff shortages were frequently claimed to be the reason for lack of training opportunities.

Career development opportunities are severely limited within Corrective Services Health Services. There simply is not a critical mass of employees to facilitate the sorts of lateral and promotional staff movements that refresh and enhance organisations and which are an aspect of employment by the Department of Health or by the major private providers. Many staff are highly-motivated and do sterling jobs beyond what can reasonably be expected of them,[66] but they are in reality, a marginalised sub-group of the broader health services profession. One consequence of this is that, although there has been some shift in this pattern, the Department still over-relies on agency nurses to fill the roster, and they often do not receive the orientation necessary to make optimum use of their services.

The Department has failed also to attract Aboriginal health workers, whose insights and approaches would enrich service provision. With more than 40 per cent of the adult and 80 per cent of the juvenile population being Aboriginal, Aboriginal health issues are core business – not some kind of afterthought or appendage. Some Aboriginal prisoners reported not attending a health centre for treatment because they did not wish to see either a female doctor or non-Aboriginal staff.

It is extraordinary to record in this context the fact that Health Services have submitted funding requests for Aboriginal Health Workers to the Prison Services Division, yet this has not been funded to date. The reason indicated to us was that this simply did not rate a

66 The corollary is that staff who are burnt out or non-performing cannot really be moved away from the frontline of patient care for a recuperative period, as there simply is no slack available in the roster situation.

sufficiently high priority within the context of the many demands upon the Prison Services Division – a point indicative of the fact that, while health is located within Prison Services for budgetary purposes, it will have to compete constantly for resources with security-related bids. The nature of a prison-focused organisation is that security considerations are always likely to prevail.

Relationships with managers, particularly those at Head Office, seemed to be strained. However, although the review team heard reports of difficulties between Head Office and prison-based nursing staff, the survey results did not reflect the high level of discontent that we had expected from anecdotal reports. Forty two per cent of staff graded the quality of their relationship with Head Office as 'very good' and 'good.'

On the whole morale was not high, however. Over half of the responses received (54%) indicated that the prison-based health services staff considered they are not involved in decision-making processes (eg. local policy) that impacted upon health services. Seventeen per cent of staff felt unable to raise concerns or grievances without repercussions, and 30 per cent felt that new ideas are not encouraged or embraced. In other words, there is a sense of constraint in dealing with management as health professionals. Local leadership was seen as 'excellent' by over 50 per cent of staff, whereas Head Office leadership was considered 'excellent' by only 16 per cent, with nearly 40 per cent rating it as 'poor.'

There is no common uniform across the system for health services staff. This may well be a symptom of a lack of pride in the Service.

The Discussion Paper discussed equipment and infrastructure issues (pages 82-84). These are variable, outmoded or unsuitable in some locations and good in others. Within its limited capacity, the Health Services Directorate is doing its best to upgrade these matters. Nevertheless, there are deficiencies; some of them of long standing, which would not be tolerated in a Health-managed model of service delivery.

Chapter 11

DISCUSSION: A CORRECTIVE SERVICES-MANAGED MODEL OR A HEALTH-MANAGED MODEL?

A key objective for the Department of Corrective Services is the security and good management of the actual prison and those held in custody, so as to provide good quality, well-coordinated and accessible justice services, with a view to contributing to a safe and orderly community and directing offenders towards the adoption of law abiding lifestyles.[67] There are eight guiding principles to attain this objective, one of which is preserving the health, safety and wellbeing of prisoners, employees and visitors and minimising the detrimental effects of imprisonment.[68]

The mission of the Department of Health is to be the principal health authority to promote, protect, maintain and restore the health of the people of Western Australia.[69] In seeking to achieve this, the Department must manage a comprehensive range of health and health-related services to all Western Australians, including health promotion, health protection, diagnosis, treatment, rehabilitation, continuing care, support and palliative care.[70] The Department of Health also states that forward planning ensures the health system confronts the challenges of the 21st century.

The Department of Health can thus be seen to embrace the accepted notion that public health is continuous and comprehensive, that it is not 'on again, off again' – in other words, that the investment in people and resources cannot be fragmented. However, prisoners' health needs become the responsibility of Corrective Services once they are sentenced. Continuity of care from the prison system back into the community is thus a public health imperative.[71]

Given the numerous health concerns that prisoners often encounter and given the possibility that these can be exacerbated by the prison environment, DOH must consider these persons when planning its general public health policies. Citizens do not cease to be citizens when they enter into the prison system. The overwhelming majority of prisoners are at some stage released back into the community, and the risks to them of blood-borne viruses, poor diets, smoking, mental health trauma, drug and alcohol problems and other chronic diseases will need to be managed by public health authorities – ultimately the Department of Health – once they are released. These risks are personal to them as patients and epidemiological in relation to those with whom they come into contact. The previously cited paper by Hobbs *et alia* emphasises the relevance and validity of this point.

Prisoners offer an ideal case for the Department of Health to make an impact upon some of the poor health situations of this population, and then continue with that care once individuals are released back into the community. Paradoxical as this may at first seem, the relatively orderly nature of their lives whilst in prison actually offers a much better opportunity to develop medication compliance habits, preventive health regimes and some notions of the importance of health self-management than were accessible to them in their

67 Department of Justice, *WA Prison System Role and Function Profile* (May 2003).
68 Ibid.
69 http://www.health.wa.gov.au/about/
70 http://www.health.wa.gov.au/about/
71 International Centre for Prison Studies, *Prison Health and Public Health: The Integration of Prison Health Services.* (April 2004).

pre-prison experience. It is for this range of reasons that the World Health Organization and the Council of Europe have both recommended that the links between prisons and public healthcare must be closer. [72]

Other jurisdictions have implemented ways to achieve this: in particular the UK and New South Wales, with Health-managed prisoner health services; and in Victoria its Justice-managed model that depends on out-sourcing and effective partnering with Health. The approach in Western Australia has been for the Corrective Services Department, as primary health service provider, to attempt to develop closer links with Health. However, as we have seen with such examples as the failure of Justice-led mental health service, Cabinet submissions and the readiness with which Health relegates prisoners services (pathology and dental services, for example) to the back of the queue when its total resources run into stress, it is not good enough to have nominally close links. The Department of Health turns out to have been a fair-weather friend to Justice, rather than a committed partner.

The evidence gathered for this Draft Report clearly indicates that prisoner health should be part of the general health services of the state rather than a specialist service under the government ministry responsible for prisons. Other jurisdictions throughout the world have taken this step of total integration, with France moving to this structure in 1994 and more recently England and Wales in 2003. In New South Wales, prisoner health services have been part of the public health system for many years and with supportive legislation.

The UK recent experience is noteworthy. The impetus for change from a Prison Medical Service to a National Health Service (NHS) model came initially from the publication in October 1996 of a thematic review, '*Patient or Prisoner? A new strategy for health care in prisons'* by the UK Chief Inspector of Prisons. In April 2003, after a long period of planning, a three-year transition program commenced. This was completed on 31 March 2006. The primary care trusts that are responsible for health service delivery in the various National Health Service administrative/geographic areas have taken over responsibility for prisons within those areas.

The UK Chief Inspector, as early as 2004, was already able to say that this change had been beneficial:

> Prison healthcare has shown considerable improvement. It has moved from a shamingly inadequate service to one that increasingly bears comparison with practice outside. It has benefited from the skills, resources and professionalism of the National Health Service; though it is important that this is integrated into prison management and culture.[73]

Of course, that does not alter the nature of the population. The Chief Inspector added: 'But here too healthcare staff struggle with the scale of the task.' It is true to say also that the patient mix is not an easy one, with arguably a greater proportion inclined to be non-compliant

72 International Centre for Prison Studies, *Prison Health and Public Health: The Integration of Prison Health Services.* (April 2004).
73 HM Chief Inspector of Prisons, *Annual Report 2003-2004*, 7.

than amongst the civilian population. That at any rate is the anecdotal impression of some practitioners who work with offender populations. Nevertheless, such problems as these are better addressed within the supportive working environment of a mainstream health service.

The NHS model has already facilitated some productive lateral thinking. A new purpose-built healthcare centre at HM Prison Preston opened early in 2006. It was designed in conjunction with the local Primary Care Trust with the objective of caring for up to 30 patients who require general post-operative nursing, clinical services and treatment. In addition, it houses an intermediate care mental health unit. The contrast with Casuarina Prison's Infirmary, which has never effectively delivered general post-operative care, is marked. So also is the contrast with the failed attempt of the Department of Corrective Services, with the nominal endorsement of the Department of Health, to obtain funding for an intermediate care mental health unit at Hakea.

Although it is early days, the initial judgment of the UK Chief Inspector of Prisons that the transfer of prisoner healthcare to the National Health Service has improved healthcare would seem to be justified.

The benefits of transferring responsibility for offenders' healthcare to the department whose core responsibility is healthcare have been documented by the International Centre for Prisoner Studies, drawing upon the experience of those jurisdictions that have done so – notably France, Norway and New South Wales.[74] They include the following:

- There is greater trust between prisoners and health staff when health services are clearly separated from prison authorities
- The continuity of care is improved
- When prison health is a mainstream discipline linked to career opportunities available across the spectrum of the public health system, it is easier to recruit better-qualified staff
- There are increased opportunities for research and training
- Responses to possible infections between prison and community can be co-ordinated (Butler's 'sentinel site' concept)
- Independent medical staff are better placed to argue for improvements in public health matters
- There is more independence for health services staff in their treatment decisions to do what is, in their view, in the patient's best interest.

Becoming part of the public health system enables the service to explore and analyse the health needs of the prison population and implement services accordingly. In NSW, the health surveys of the inmate population enabled that service to guide the provision of healthcare, rather than merely being reactive to daily prisoner needs. Health professionals can become

74 International Centre for Prison Studies, *Prison Health and Public Health: The Integration of Prison Health Services.* (April 2004).

more active in policy development and have a voice in the prison in terms of diets, effects of punishment on the mental health of prisoners and the effects of overcrowding. Rather than just being a small component of the prison establishment, when integrated into the public health service health professionals consider, and have a say in, the health of the whole prison. The experience in NSW has been that a good health service does in fact benefit the whole prison and assist in achieving an ordered environment.

The Reid Report 2004 (the West Australian Health Reform Committee Report – *A Healthy Future for Western Australians*) recommends that: area health services be further developed and enhance their responsibility for the health of the population within their catchment area (recommendation 61). Furthermore, that the role of the Area Chief Executives should be focused on improving and maintaining the health of the area's population and the management of all health services (recommendation 64). These concepts parallel the administrative/geographic touchstone of healthcare delivery that is at the root of the UK National Health Service. *The Reid Report's* views as to the necessity for integrating area health services, rather than discriminating between types of patient, are cogent. The philosophy of the report also implies regional equivalence of services. Corrective Health Services is, at present, excessively Perth-centric, with regional (particularly Aboriginal prisons) under-resourced in relation to the needs of the population.

An integrated health service is also better placed to address issues of health promotion. The current performance of the Corrective Services Health Services Directorate has been tokenistic – doubtless because of resource problems – whilst its formal position, stated in response to the Discussion Paper, can only be described as confused: 'It is unrealistic to state that the Department of Justice will provide information that will improve the health and wellbeing of all prisoners. Ultimately, prisoners have control over their health and wellbeing. It is possible to say however that the Department will provide information to optimise the health of prisoners.'

However, the stark fact is that prisoners have quite limited control over their health and wellbeing. Their control over such matters as to the choice of a doctor, their living conditions and their diet, the availability of medications, access to fresh air and their exercise regime, is really quite restricted. They are frequently moved throughout the system, changing prisons because of overcrowding or because of the need to access programs for their offending behaviour.

Yet the Health Services own *Strategic Directions 2005-2010* document, acknowledged that 'healthcare in the justice system has historically been reactive, with a high level of acute care being provided.' Very few prison health centres have available time or resources to undertake health programs.

The Department of Health, being responsible for the health of the WA population, is better placed to argue for services that will target the health needs of prisoners. As noted above, this is one of the benefits promoting the transfer of responsibility from Corrective Services to Health.

DISCUSSION: A CORRECTIVE SERVICES-MANAGED MODEL OR A HEALTH-MANAGED MODEL?

When contemplating the possibility of a transfer of responsibility, Western Australia can learn a great deal from the transfer process elsewhere, noting potential problem areas and addressing them here before they impact upon the system elsewhere. These issues are informatively discussed in the previously mentioned Report of the International Centre for Prison Studies, *Prison Health and Public Health: The Integration of Prison Health Services.* Within the UK specifically, issues that have been noted[75] relating to the transfer process include:

- Ensuring that the senior management team of the prison includes healthcare (recognised as critical for smooth operations of the establishment)
- The model of care reflects need of prison population – thus it would be different in an 'Aboriginal prison' than in a metropolitan pre-release prison
- Effective throughcare for prisoners with serious mental health problems is crucial
- There must be integrated planning and smooth throughcare for substance abuse users
- Health promotion initiatives must be identified and applied
- Staff should be informed about health plans and incoming staff trained in areas relating to the custodial environment.

It has been pointed out in response to the Discussion Paper, that a transfer was easier to achieve in the UK because the National Health Service is the legal employer of core health services staff; that being so, they can be directed where to work, including in a prison or other custodial setting. The structure of the health professions in Western Australia is more diverse, with a far greater proportion of personnel working as sole practitioners or in private practice. There could be resistance or simply refusal to work in what many would regard as unattractive workplaces.

Doubtless, there is some truth to this objection. However, experience in New South Wales, with a Health-managed model, and in Victoria, with its mixed model, drawing upon a wide range of private as well as public providers, suggests that this problem should not be insuperable. Like many such challenges, it will probably depend on how and when it is done and with what incentives.

Apart from this, the question arises: would the Department of Health, with its previous record of ambivalence towards prisoner health services, accept the responsibility for the provision of such services in the committed way and with the positive spirit that is required? The answer must inevitably be that, once it is made clear by Government that this is the path down which we must ultimately go, it would be done with the sense of professionalism and commitment that it brings to every other aspect of its service provision.

The peculiar bureaucratic arrangement whereby a core state service – health – has hitherto not been the responsibility of the core state service provider – the Health Department – could be said positively to have invited ambivalence by Health. The regularisation of the arrangement would bring prisoner health services onto the same basis as every other

75 *Signposting to Prison Health: Learning from Wave 1 Transfer* (University of Birmingham: Health Services Management Centre, 2004).

responsibility of the Health Department and would, we are sure, be treated as such in a fully professional and committed manner.

The transfer of primary responsibility would have to be carefully managed. Transitional arrangements would have to be robust. The funding that Corrective Services puts into health services would have to be accurately estimated, and that amount transferred to Health. Transitional staffing arrangements would need to be established. Protocols as to the relationship between Health-employed staff and Corrective Services-employed custodial and other staff would need to be clarified. These would include issues as to entry into and movement within prisons, as well as the accessibility of patients. The Health-managed operation would need to satisfy itself that the standard of the health centres and the medical equipment were of an appropriate standard, though in that regard the granting of ACHS accreditation has taken the matter a long way down the track. A new costing and service model would need to be developed – though this process could not really be completed until a comprehensive health status profile of the prisoner population was established.

The Offender Health Council is well positioned, in principle, to oversee this transfer process. It is the natural forum for the discussion and resolution of policy problems that might arise along the way, particularly as its reporting lines are to the respective ministers. However, the council only meets twice a year, so possibly it would be more efficient to establish a Project Control Group of some kind from within the Offender Health Council to ensure that day-to-day momentum is maintained.

In the UK, just over two years elapsed between the decision, in principle, to transfer Prison Health Services from the Prison Service to the National Health Service and the commencement of the transfer arrangements underpinning the new system. Western Australia is a considerably less complex jurisdiction, and a two-year planning target plus a two-year transfer period should be attainable. Until this is done, health services for prisoners will not fully meet acceptable public interest/public health criteria.

Chapter 12

RECOMMENDATIONS

With minor amendments and additions, the recommendations set out below replicate those foreshadowed in the Discussion Paper. Several of these matters have not been explicitly re-stated in this Report,[76] and in such cases fuller data and argumentation will be found, if required, in that Discussion Paper.

1. That responsibility for the provision of health services for prisoners and juvenile detainees should be transferred from the Department of Corrective Services to the Department of Health.

2. That the Department of Health and the Department of Corrective Services negotiate and jointly manage a transition plan for the transfer of responsibility and the provision of health services. The transition should occur within the broad timelines mentioned above, ie. no more than two years.

3. That the transition process should be managed in such a way as to protect the interests of existing employees of the Department of Corrective Services Health Services Directorate.

4. That parallel arrangements should be made in relation to prisoner health services at Acacia Prison.

5. That the Offender Health Council should continue to act as the broad policy-setting body for these services and that in the event of disagreements between Corrective Services and Health on transitional matters, the Council should be available to offer its advice to the relevant ministers.

6. That all necessary legislative amendments to authorise and support the above should be put in place.[77]

The following recommendations apply whether the foregoing recommendations are accepted or not, or if they are accepted but implementation is delayed:

(a) A health status survey of the prison and juvenile detention populations, along the lines of the NSW model, must be carried out as soon as possible so as to ascertain the service needs of these populations

(b) In the light of the findings, priorities should be clearly articulated

(c) Available funding and other resources should be re-assessed in the light of these priorities and brought up to a standard sufficient to deliver the required services

(d) The outstanding ACHS recommendations should be implemented as required and a strategy developed to retain accreditation

(e) Plans for a secure forensic prison should be affirmed and implemented

(f) A secure hospital ward, along the lines of the St. Augustine's Ward in St. Vincent's Hospital, Melbourne, should be planned and made operational in an appropriate Perth Metropolitan Hospital

76 This comment refers, in particular, to Recommendation 4 and sub-recommendations (d), (f), (m) and (p). Sub-recommendations (j) and (k) were not covered in the original Discussion Paper.

77 A Department of Health Discussion Paper of June 2005, argues for the drafting of a new Public Health Act for Western Australia, and it is understood that drafting has now commenced. The matter is timely, therefore, and the new legislation should provide a receptive vehicle for the legislative aspects of the proposed new arrangement.

(g) The utilisation of the currently available resources in the three main metropolitan secure prisons should be reviewed so as to optimise service provision in a systemic manner, and in particular specialist sites for secondary care (Casuarina), crisis care (Hakea) and assisted care (Acacia) should be further consolidated

(h) A comprehensive women's health policy, taking in the needs of women in regional prisons, as well as those at Bandyup and Boronia, should be developed and implemented

(i) Links with Aboriginal Health Services must be strengthened in such a way as to make that service a core component of Prisoner Health Services

(j) A comprehensive adolescent and juvenile health policy should be developed and implemented

(k) A comprehensive policy relating to the health management of physically and intellectually disabled prisoners should be developed

(l) Opiate replacement pharmacotherapy programs should be reviewed and the question of supporting counselling and cognitive courses addressed

(m) The new AIMS transport contract should be monitored and if necessary reviewed from the point of view of the adequacy of medical escorts

(n) Health promotion programs within prisons and juvenile detention centres should be reviewed and improved

(o) Throughcare arrangements for released prisoners should be reviewed and improved

(p) Investigations should be made to identify specialist-credentialing arrangements, for staff working in prison health and related services.

Appendix 1

DEPARTMENT OF CORRECTIVE SERVICES RESPONSE
TO THE 2006 RECOMMENDATIONS

Recommendation	**Acceptance Level/Risk Rating/**Response
1. That responsibility for the provision of health services for prisoners and juvenile detainees should be transferred from the Department of Corrective Services to the Department of Health.	**Agree/Very High** To transfer the responsibility to the Health Department of Western Australia (HDWA) there must be a shared vision and full commitment by Government and The Chief Executive Officers (CEOs) of the Department of Corrective Services (DCS) and the HDWA.
2. That the Department of Health and the Department of Corrective Services negotiate and jointly manage a transition plan for the transfer of responsibility and the provision of health services.	**Agree/Very High** The transition of responsibility would also need the full support of the CEOs and there would need to be a body appointed to oversee the process. The Offender Health Council with both CEOs as members may be the appropriate body. A full assessment of the risks would need to be carried out and a detailed transition plan, informed by best practice from other jurisdictions, developed. Significant resources would be needed to give proper effect to the transition process.
3. The transition process should be managed in such a way as to protect the interests of existing employees of the Department of Corrective Services Health Services Directorate.	**Agree/High** Agree
4. That parallel arrangements should be made in relation to prisoner health services at Acacia Prison.	**Agree/Very High** The Acacia health service is already severely compromised by inability to recruit and retain staff and already has service 'quality' issues. Added complexity of the arrangements is likely to prove this process impossible.

Recommendation		Acceptance Level/Risk Rating/Response
5.	That the Offender Health Council should continue to act as the broad policy-setting body for these services and that in the event of disagreements between Corrective Services and Health on transitional matters, the Council shall be available to offer its advice to the relevant ministers.	**Agree/Low** Agree.
6.	That all necessary legislative amendments to authorise and support the above should be put in place.	**Noted** Noted.
The following recommendations apply whether the foregoing recommendations are accepted or not, or if they are accepted but implementation is delayed:		
a)	A health status survey of the prison and juvenile detention populations, along the lines of the NSW model, must be carried out as soon as possible so as to ascertain the service needs of these populations.	**Agree/Very High** Health Services needs to be funded $750k to undertake this survey. It will provide invaluable data to better inform health service delivery.
b)	In the light of the findings, priorities should be clearly articulated.	**Agree/Very High** Although the deficits in service provision are very apparent without data to back this up, appropriate funding is not likely to be provided.
c)	Available funding and other resources should be re-assessed in the light of these priorities and brought up to a standard sufficient to deliver the required services.	**Agree/Very High** Budget bids have attempted to address the clearly identified service deficits. DCS will continue to seek funding at every opportunity and work in collaboration with the HDWA.

Recommendation	Acceptance Level/Risk Rating/Response
d) Outstanding ACHS recommendations should be implemented as required and a strategy developed to retain accreditation.	**Agree/Low** These are being addressed. A requirement for the upcoming ACHS survey in May 2006. Again funding only allows for small portions of this work to be undertaken. There is insufficient staff available to undertake the Q&A work required for reaccreditation.
e) Plans for a secure forensic prison should be affirmed and implemented.	**Disagree** Several options for management of forensic mental health services are contained in a business case that has been submitted to Government. However, this strategy provides funds for facilities for a very small number of high profile DS&PD offenders. Further funding is required to provide for skilled and specialised staff to properly manage mental health in prisons and detention centres.
f) A secure hospital ward, along the lines of St. Augustine's Ward in St. Vincent's Hospital Melbourne, should be planned and made operational in an appropriate Perth Metropolitan Hospital.	**Disagree/Low** DCS is currently preparing to commence construction of a new secure, out-patients clinic located under the recently opened RPH out-patients centre. Discussions have commenced with RPH concerning the establishment of secure beds at the new Fiona Stanley Hospital. This again, will provide similar benefits as the out-patients clinic for prisoners requiring admittance to hospitals.
g) The utilisation of the currently available resources in the three main metropolitan secure prisons should be reviewed so as to optimise service provision in a systemic manner, and in particular specialist sites for secondary care (Casuarina), crisis care (Hakea) and assisted care (Acacia) should be further consolidated.	**Agree/Moderate** This is underway. Health Services are currently engaging the new contractor for Acacia with regard to the 'Aged care facility.'

Recommendation		Acceptance Level/Risk Rating/Response
h)	A comprehensive women's health policy, taking in the needs of women in regional prisons as well as those at Bandyup and Boronia, should be developed and implemented.	**Agree/Low** Although there is no specific policy, Health Services has comprehensive strategies to address the health of female patients in custody with extensive engagement of community-based providers (FPWA Maries Stopes, Breast Screen, Curtin University, ECU and community health).
i)	Links with Aboriginal Health Services must be strengthened in such a way as to make that service a core component of Prisoner Health Services.	**Agree/High** BEGA, BRAMS, GRAMS and SWAMS are current service providers to adult custodial health. Management issues and rapid staff (medical and administrative) turnover make these extremely difficult contracts to maintain and very difficult to manage under ACC and contracting guidelines.
j)	A comprehensive adolescent and juvenile health policy should be developed and implemented.	**Agree/Low** This is under development as we review all of Health Services standards policies and procedures. Discussions have commenced with RPH concerning the establishment of secure beds at the new Fiona Stanley Hospital. This again, will provide similar benefits as the out-patients clinic for prisoners requiring admittance to hospitals.
k)	A comprehensive policy relating to the health management of physically and intellectually disabled prisoners should be developed.	**Agree/Low** This is under development as we review all of Health Services standards policies and procedures.
l)	Opiate replacement pharmacotherapy programs should be reviewed and the question of supporting counselling and cognitive courses addressed.	**Agree/Low** The pharmacotherapy program has been working effectively and is now an accepted and integral part of prisons. Brief Interventions are now part of the program for remand and short term prisoners.

Recommendation	**Acceptance Level/Risk Rating/**Response
m) The new AIMS transport contract should be monitored and if necessary reviewed from the point of view of the adequacy of medical escorts.	**Agree/Moderate** In the past, the resources available under the Court Security and Custodial Services Contract were greatly diminished due to the inability of the contractor to maintain a suitable level of staffing. This had a major impact on all services, including the ability to perform medical escorts. Since that time, AIMS has been able to raise its staffing level to a point where medical cancellations are as low as 5 per cent – 8 per cent. These cancellations are normally the result of several appointments all being made at the same time. However, this current figure is comparable to cancellations due to the facilities (hospitals and prisons) and is considerably less than cancellations due to the prisoners refusing to attend. Despite this improvement, the Department, in conjunction with the contractor, has instigated several measures to better improve the service delivery. The first was introduced in February 2005, whereby medicals were allocated a priority based on a triage policy. This provided the contractor with the ability to focus its resources on those appointments with a higher priority if cancellations were being considered. DCS is currently preparing to commence construction of a new secure, out-patients clinic located under the recently opened RPH out-patients centre. This facility will further enhance the service provided by removing the need to have prisoners escorted through public areas and thereby reduce the risks to staff and the general public. Also, as visitations will occur in a secure environment, there will be no need for restraints creating a more proper environment for medical consultation.

Recommendation		Acceptance Level/Risk Rating/Response
		Some discussions have already commenced with RPH concerning the establishment of secure beds at the new Fiona Stanley Hospital. This again, will provide similar benefits as the out-patients clinic for prisoners requiring admittance to hospitals. All these initiatives above have considerably improved the level of service delivery in this area. Any consideration on the future provision of these services, whether, in-house or outsourced, will ensure their continued operation.
n)	Health promotion programs within prisons and juvenile detention centres should be reviewed and improved.	**Agree/Low** This is being addressed. Chronic Disease Management Strategy incorporates Care Planning, health promotion and illness prevention programs. No funding has been provided for this, despite requests.
o)	Throughcare arrangements for released prisoners should be reviewed and improved.	**Agree/Moderate** This is being addressed: SHIP project (this is a state-of-the-art electronic shared discharge summary which has been developed within HS), Care Planning Program.
p)	Investigations should be made to identify specialist-credentialing arrangements for staff working in prison health and related services.	**Agree/Low** Professor Mary Chiarella has just completed a comprehensive review of nursing within the WA custodial environment. We await the report.

Appendix 2

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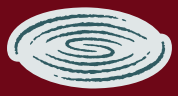
Attachment 1

CD - DISCUSSION PAPER – PRISONER HEALTH SERVICES, SEPTEMBER 2005 AND DIGEST OF CUSTODIAL-HEALTH RELATED FINDINGS AS REPORTED IN PUBLISHED INSPECTIONS REPORTS 2000-2005



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