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Prisoner health services in Australia

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Summary

This bulletin provides an overview of health services in Australian prisons. It draws on data available from the 2012 National Prisoner Health Data Collection, supplemented by contextual information provided by state/territory departments responsible for prisoner health, to bring together a more comprehensive picture of services delivered to prisoners than has previously been available.

Principles for prisoner health focus on equivalent health care

International frameworks from the United Nations (UN) and the World Health Organization (WHO), supported by national principles in Australia, stipulate that prisoners should receive health care equivalent to that available in their community, without discrimination based on their legal situation. Prisoners are known to be a population with chronic and complex health and mental health conditions, and prison provides an opportunity for these health issues to be reviewed.

The governance of health care in prisons in Australia is complex

State and territory governments are responsible for prisoner health. This is in contrast to people in the general community for whom both the national and state and territory governments are the key funders of health care. In some states and territories, the local Department of Health provides health services in prisons, and in others, it is the responsibility of the Department of Justice or Corrections. Most jurisdictions use a mix of directly provided services, community health services and contracted health services. The provision of mental health services and alcohol and other drug services is particularly complex. The infrastructure and security requirements of a prison further complicate the delivery of health services to prisoners.

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Health services delivered to prisoners are diverse

During a 2-week data collection period in 2012, it was found that 26% of male and 38% of female prisoners visited the prison health clinic. The most commonly managed problems were medication/vaccination, general health assessments, pathology, psychological/mental health, diabetes and drug and alcohol treatment.

Health services in prisons predominantly use a nurse-led care model, with a nurse being the health professional consulted in more than two-thirds of visits to the prison clinic. A doctor or medical practitioner was consulted in 1 in 5 visits.

Over half (55%) of female prisoners and about 4 in 10 male prisoners (37%) were taking prescribed medications during the data collection period.

A range of health services are delivered outside the prison

Sometimes prisoners are transferred out of the prison to access health services, such as radiology, surgical procedures or where specialist care is required. About half (49%) of prisoners who had been in prison for between 1 and 2 years, and were expecting to be released within the 4 weeks following data collection, had accessed health care in the community during their time in prison. These included visits to an emergency department of a hospital, as well as scheduled medical appointments.

Contents

Introduction

This bulletin was developed to supplement information available in the major report based on the 2012 National Prisoner Health Data Collection (NPHDC) (AIHW 2013) by providing contextual information about prisoner health service delivery in Australia. Although the NPHDC aims to capture information on all health services provided to prisoners in the prison clinic, the complexities of these state/territory based systems mean that it is difficult to cover all aspects of this service delivery.

This bulletin provides an overview of the data currently available from the NPHDC, supplemented with a description of other health services provided to prisoners that are not captured in the NPHDC. This includes information on other types of health services, how they are funded, and where and by whom they are delivered. It also discusses the challenges associated with capturing data concerning health service use. The information throughout this bulletin adds to existing research relating to the health services provided to prisoners.

It is widely accepted that prisoners have greater health needs than many others in the general population and that the services made available by prisons provide an opportunity for health intervention. Health services are activities that assess, maintain or improve health, and diagnose or treat an illness, injury or disability, or suspected illness, injury or disability. A health service can also include a disability, palliative or aged care service, or the dispensing of a prescription by a pharmacist (Australian Law Reform Commission 2014).

In Australia, prisoner health is a state and territory, rather than federal, government responsibility, so the manner in which health services are delivered to prisoners varies among jurisdictions. Numerous approaches are taken, including direct service provision, access to community-based services or through contracted external providers. Although prisoner health service delivery differs among jurisdictions, there are fundamental frameworks and principles adopted by jurisdictions that serve as guides; these are discussed below.

Data in this bulletin are sourced from the 3rd NPHDC in Australia, conducted in 2012. Data were collected from prison entrants, a selection of current prisoners and, for the first time, the NPHDC was extended to include prisoners about to be released to the community—referred to as 'dischargees'. Some additional data and information provided in this bulletin have been obtained directly from jurisdictions.

The following should be noted in relation to the information in this bulletin:

- Data relating to entrants and dischargees are self-reported.
- Participation rates for dischargees were relatively low when compared with entrants (see AIHW 2013) and the data should be treated as indicative only.
- Western Australia did not participate in the 2012 data collection.
- Mount Gambier Prison (South Australia) did not participate in the 2012 data collection.

Frameworks for delivering prisoner health care

There are international frameworks for best practice that guide the models of delivery of prisoner health services in Australia. These include the following:

- The *Standard Minimum Rules For the Treatment of Prisoners* (1955) from the Office of the High Commissioner for Human Rights outlines the basic rules regarding medical services, including having medical officers available, including those related to psychiatry, transferring sick prisoners who require specialist treatment to the appropriate facility and having dentists available (UN 1955).
- The *United Nations' Basic Principles for the Treatment of Prisoners* (1990) provides that prisoners must have health services available without discrimination based on their legal situation (UN 1990).
- The *Principles for the protection of persons with mental illness and the improvement of mental health care* (1991) outlines the basic details regarding the protection of people with mental health disorders and improving their condition. It includes, for example: the right to treatment following informed consent; that physical restraint or involuntary seclusion only be implemented in accordance with official procedures and when it is the only option; and that any patient admitted to any mental health facility should always be informed of their rights (UN 1991).
- *Trenčín statement on prisons and mental health* (2007) recognises the high proportion of prisoners with mental health problems. Key criteria include diverting such prisoners to psychiatric care where appropriate, having central policies that promote mental health and wellbeing, and providing general health care that is as equivalent as possible to that available in the community (WHO 2008).

Principles for delivering prisoner health care

In addition to international frameworks that outline best practice, there are both national and international principles that serve to guide the delivery of prisoner health care among jurisdictions in Australia.

The concept of community equivalence has been adopted as a benchmark for the delivery of prisoner health services. The Australian Medical Association Position Statement, *Healthcare of Prisoners and Detainees* (1998), states that prisoners have the same right of access, equity and quality of health care as the general population. This position remains unchanged in the AMA's 2013 *Position statement on medical ethics in custodial settings* (AMA 2013).

Focusing on health promotion and disease prevention as recommended by the *Ottawa charter for health promotion* (WHO 1986) is essential in preventing illness and improving the health of people in custody. Health services aim to ensure that the health of prisoners is not worsened by their incarceration and that the opportunity is taken to manage health conditions and influence risky behaviours (Corrective Services WA 2010). Promotion and prevention activities targeting prisoners often include alcohol and drug use prevention, sexual health and smoking cessation support.

There are ethical implications associated with delivering health care within a secure environment such as a prison. The AMA's 2013 Position Statement on *Medical Ethics in Custodial Settings* supports the independence and professional autonomy of medical practitioners, protects clinical independence and integrity from interference and ensures that professional independence of health professionals are not compromised by virtue of their employment in custodial settings (AMA 2013). To support clinical independence, most jurisdictions in Australia split custodial responsibility and the provision of prisoner health care between agencies.

The prisoner population is a transient population, with prisoners regularly entering or returning to prison and serving short sentences, which can make continuity of care for people entering and exiting prisons problematic. Continuity of care is supported by developing clear and consistent policies, procedures, practices and pathways to ensure service delivery and minimise the risks associated with fragmented care.

Governance of prisoner health in Australia

The provision of health services to prisoners is different to that of the general population, both in terms of which level of government, and which government department has responsibility. Governance arrangements for prisoner health services in Australia vary by jurisdiction, with prisoner health services governed by either the state or territory government corrective services or justice department, or the relevant health department, depending on the jurisdiction.

Medicare is the taxpayer-funded scheme that enables residents of Australia to have free or subsidised health care by health professionals such as doctors and specialists, including free treatment and accommodation in a public hospital, and subsidised treatment as a private patient in public or private hospitals. Medicare also entitles Australian residents to the Pharmaceutical Benefits Scheme (PBS), which provides medicines at a lower cost. Expenditure on primary health care in the general community is wholly the responsibility of the Commonwealth Government through Medicare (including the PBS). Medicare excludes services provided by jurisdictional authorities, which therefore excludes prisoner health services. Prisoners can only access Schedule 100 of the PBS, known as the Highly Specialised Drugs Program. All other pharmaceuticals are also the responsibility of state and territory governments.

Health agencies work in collaboration with the agency responsible for managing prisons in their jurisdiction. Responsibilities for prison health services in each jurisdiction are set out in Table 1.

Table 1: Agency responsible for prison health services, states and territories, 2014

	Department of Health/ Justice Health	Department of Corrective Services	Department of Justice (Justice Health)
New South Wales	✓		
Victoria			✓
Queensland	✓		
Western Australia		✓	
South Australia	✓		
Tasmania	✓		
Australian Capital Territory	✓		
Northern Territory	✓		

Victoria's service is managed by an independent unit in the Department of Justice, Justice Health. New South Wales, Victoria, Queensland, South Australia and Western Australia each use a combination of publicly and privately operated prisons and the arrangements for prison health services differ among prisons and service types. Some contract out their health services to external providers. Privately run prisons have privately contracted services.

Delivering prisoner health services

The variations in governance of prisoner health services cause variations among jurisdictions in the models of service delivery. Most jurisdictions use an assortment of mechanisms for delivering prisoner health services, which may include direct service provision, access to community-based services or through a contracted external provider.

In South Australia, for example, primary health care is delivered in prisons and most secondary, tertiary and some allied health care services are provided off site through the public health system, whereas in New South Wales, Victoria and the Australian Capital Territory, a variety of primary, secondary and some low level tertiary services are available on site.

More detail on these jurisdictional differences is provided in the section 'Health services information not previously available' later in this bulletin. The different kinds of health care will first be explained.

Primary health care

In each jurisdiction, primary health care is available at all prisons. Most jurisdictions also use community-based services to complement primary health care in prison. Services that may be accessed in the community from community-based providers include diagnostic imaging, pharmacy and pathology. Jurisdictions with regionally isolated prisons may also use community-based in-reach services, such as general practitioners, to provide primary health care.

In prisons, primary health care tends to be delivered by nurses. Primary health care refers to an individual or community's first level of contact with the health care system, providing '…promotive, preventive, curative and rehabilitative services…' (WHO 1978). In the community, a lot of primary care is undertaken by general practitioners, with

patients usually only seeing a nurse when they initially attend an accident and emergency department in a hospital, or increasingly for services such as vaccinations in general practice. In prison, however, nurse-led care is the dominant model, with some of the most common services such as general health assessments following reception or transfer, medication and vaccinations being predominately provided by nurses (see Table 3).

Secondary and tertiary health care

Like primary health services, most jurisdictions provide some secondary and low-level tertiary services within the prison system. Secondary health care refers to health care services provided by medical specialists, usually on referral from a primary health care provider. Tertiary health care is specialised consultative health care, and may include services such as cancer management. All jurisdictions access some secondary and/or tertiary health services in the community. These include some general hospital inpatient and emergency care.

Specialist mental health care

All jurisdictions offer access to specialist mental health care. Tertiary (involuntary) care is offered outside of the prison system. Specialist mental health services in prisons are often delivered in collaboration with local community mental health services.

Health services used for addressing criminal behaviour

In most prisons, both corrections and health services provide psychological services. The roles of these 2 services are quite distinct. Health services are responsible for responding to the mental health needs of prisoners; corrections services usually use psychological services to respond to the criminogenic—that is, criminality producing or tendency to produce criminality—aspects of the prisoner's issues.

Alcohol and other drugs (AOD) treatment is another service that may be delivered for both health and criminogenic purposes. The service delivery complexities and variations among jurisdictions may mean that some mental health and AOD services in some jurisdictions are not currently captured in the NPHDC.

Providing health care in a prison setting

Prisoner health services are obliged to operate according to an 'equivalence of care' principle, which requires that prisoners are provided with care of equivalent quality to that provided in the general community in the same country. Numerous national and international directives and recommendations make reference to this principle (Niveau 2007). Equivalence of care is difficult to translate from community to prison settings at times, and may not account for the increased need in prison. Some argue that there is an obligation to provide health care at a greater standard than in the community and equivalence should be the minimum rather than the ideal (Exworthy et al. 2012).

Prison health services aim to deliver health services that mitigate risk factors prevalent among the population by responding to new and existing illnesses in a way appropriate to the sex, ethnicity and age of the prison populations. Health services aim to ensure the health of prisoners is not worsened by their incarceration and that the opportunity is taken to manage health conditions and influence risky behaviours (National Health Committee 2010; Corrective Services WA 2010).

Although similarities to community-provided health care exist, prison is a unique environment that complicates health service delivery. The infrastructure and security requirements of the prison environment are just some of the challenges faced (Powell et al. 2010). Some prisoners are not able to freely move around within the grounds of the prison, so, despite usually having the advantage of some health services on site, in between are locked doors and gates controlled by others. This means that, although prisoners may need to make an appointment to see a doctor as they would in the community, it may depend on prison security staff bringing them a request form to visit health services, or to bring their health issue to the attention of clinic staff. Even in emergency situations requiring an ambulance, security considerations are paramount, adding a layer of complexity to delivering and accessing health services.

The lack of freedom for prisoners extends further than restrictions on movement around the prison grounds. Upon incarceration, prisoners automatically lose many social connections related to their health and wellbeing, including to the ability to control their circumstances; social support from family and friends; and a general lack of availability to health information (WHO 2007). Most of the time prisoners are unable to choose which medical professional will look after their health, and similarly primary health care teams are unable to choose their patients (WHO 2007; Bjørngaard et al. 2009).

Prisoner use of health services

Prisoners have been found to use health services 3–4 times more often than the general population, which can be linked to, but not completely explained by, higher morbidity (Feron et al. 2005; Nobile et al. 2011). Similarly, Marshall and others (2001) found that male prisoners consulted a doctor, on average, 6 times per year—3 times as often as their peers in the community—and female prisoners visited a doctor an average of 14 times per year, which is 3 times the community average. Some explanations for this could include lack of access to informal care coupled with good access to formal care so that prisoners are visiting the clinic where they may otherwise have consulted family members, the institutional culture in prisons, and the lack of opportunities for prisoners to look after aspects of their own health. For example, prisoners may have to attend the clinic for issues that, had they been in the community, they might have otherwise attended a pharmacy for, or self-administered medication already in their possession, which could inflate their clinic attendances (noting that collection and receipt of medications is not recorded as a service in all jurisdictions; for example, in Victoria). Details of the reasons prisoners attend health clinics are provided later in this bulletin.

Results from the 2012 NPHDC

This section expands upon findings from the NPHDC, conducted in May 2012, which captured data from prisoners in all jurisdictions except Western Australia. As noted earlier in this bulletin, the provision of health services to prisoners in Australia is complex, given the variations in governance and funding arrangements within and among jurisdictions. Although the NPHDC aims to capture information on all health services provided to prisoners in the prison clinic, these complexities make it difficult to cover all aspects of this service delivery. Therefore, for some jurisdictions in particular, data from the NPHDC is an incomplete picture of health service provision to prisoners. Further to this: some health services may be provided within the prison grounds, but not at the prison clinic; the health professional may not be employed by the relevant health department; and for some types of services, the prisoner will have to transfer outside prison grounds. The NPHDC included data relating to:

- 794 prison entrants received at prison during the 2-week data collection period
- 387 dischargees released from prison during the same period
- 4,058 prisoners who visited the prison clinic during the 2 weeks
- every prescribed medication administered on 1 day of the data collection period—21,766 medications.

Information from prison entrants and dischargees was self-reported; however, attendance at the prison clinic and medication use was reported by the service provider. Some administrative data relating to the operations of the prison clinic (such as the number of hospital transfers) were provided by nursing unit managers in each prison. The full report on 2013 NPHDC results (*The health of Australia's prisoners 2012*) can be accessed online at <www.aihw.gov.au/prisoner-health-publications/> (AIHW 2013).

Visits to the prison clinic

During the 2-week data collection period, more than 4,000 prisoners in custody visited a prison clinic. As a proportion of all prisoners in custody on 30 June 2012, this equates to 26% of males and 38% of females. These prisoners made a total of 6,941 visits to a prison clinic. Spread over the 14 days of the data collection period, this equates to 496 visits to prison clinics per day, or about 11–12 visits to each of the 44 prison clinics each day. These clinic data exclude New South Wales services because they did not provide complete clinic data, and exclude Western Australia, and Mt Gambier Prison in SA because they did not participate in the 2012 data collection.

More than 9,000 problems were managed at the prison clinic during the data collection period. The most common problem managed was related to medication/vaccination (other than the administration of routine medications), representing around 1 in 5 (21%) problems managed and almost 1 in 10 prisoners (9%). General health assessments (14%), pathology (8%), psychological/mental health (7%), diabetes (6%) and drug and alcohol use (5%) were also among the most commonly managed problems (Table 2). The data collection coincided with the time of year where flu vaccinations are generally administered in prisons, which may have skewed data for the 'medication/vaccination' category. The same category may include some over-the-counter medications not freely available in the prison system.

The most commonly managed problems in the clinic may include some problems that require multiple clinic visits by the same prisoners. These problems may represent a high proportion of problems managed at the clinic, but a smaller proportion of prisoners. For example, despite diabetes being among the most commonly managed problems, only 1% of prisoners in custody visited the clinic for that reason. This may be because diabetes was a problem for which prisoners tended to make multiple visits during the data collection period.

Table 2: Problems managed in prison clinics during the data collection period, 2012

Problem managed	Number of problems managed	Percentage of problems managed	Number of prisoners	Percentage of prisoners in custody
Medication/vaccination	1,906	21	1,319	9
General health assessment	1,228	14	968	7
Pathology	748	8	682	5
Psychological/mental health	632	7	501	3
Diabetes	562	6	217	1
Drug and alcohol use	448	5	315	2
Wound care	447	5	283	2
Skin condition	429	5	368	3
Musculoskeletal injury	389	4	345	2
Dental	382	4	352	2
Cardiovascular disease	242	3	190	1
Musculoskeletal condition	231	3	218	2
Communicable disease	218	2	199	1
Other	173	2	166	1
Respiratory condition	169	2	143	1
Sensory (including ear and eye condition)	166	2	149	1
Digestive condition	139	2	128	1
Asthma	97	1	88	1
Neurological	94	1	83	1
Women's health	72	1	52	<1
Quitting smoking	55	1	49	<1
Arthritis	51	1	48	<1
Pain management	32	<1	29	<1
Advice and education	20	<1	20	<1
Malignancy	14	<1	14	<1
Total	**9,027**	**100**	**14,089 prisoners in custody**	**100**

Notes
1. Excludes Western Australia, as they did not participate in the 2012 NPHDC.
2. Excludes New South Wales as they did not provide complete clinic data.
3. Excludes Townsville Correctional Centre, as they did not provide complete Clinic and Medication data.
4. Totals include 83 instances where the problem managed was unknown.
5. Excludes visits to the prison clinic during the data collection period for routine provision of medication.

Source: Clinic form, 2012 NPHDC.

The service received at each clinic visit was recorded. Services included assessment, advice and education, treatment and referral. Treatment was provided at about 2 out of 5 (40%) clinic visits, making it the most common reason for a clinic visit. Assessments were performed at just under one-third (29%) of visits and advice and education was provided at around 1 in 5 (21%) visits. Referrals were provided at 7% of visits.

The range of health professionals working in prison clinics varied among prisons and among jurisdictions. Reflecting the predominant nurse-led care model, in more than two-thirds (69%) of clinic visits, the health professional consulted was a nurse. A general practitioner (GP) was consulted in 1 in 5 visits (20%).

Consistent with this, nurses were consulted the most of all health professionals for the most common health conditions (Table 3). Nurses handled about 9 out of 10 diabetes cases (88%) and medication and vaccination (86%), as well as over two-thirds of general health assessments (70%) and over half of all alcohol and drug use cases (57%). Consults for psychological conditions were managed by nurses (42%), GPs (23%), mental health nurses (17%) and psychiatrists (13%).

Table 3: Health professional consulted at prison clinic visits, selected problems managed, 2012

	General health assessment	Diabetes	Psychological/ mental health	Pathology	Alcohol or drug use	Medicine/ vaccination
			Number			
Nurse	1,052	603	348	684	354	1,821
Medical practitioner/GP	399	63	187	135	192	205
Mental health nurse/team	27	1	140	1	4	19
Psychiatrist	1	3	106	4	6	16
Alcohol and drug worker	—	—	1	—	35	3
Psychologist	—	—	23	—	—	1
Aboriginal health worker	9	1	4	1	—	1
Other	6	—	1	14	20	12
Total	**1,513**	**683**	**819**	**855**	**616**	**2,115**
			%			
Nurse	70	88	42	80	57	86
Medical practitioner/GP	26	9	23	16	31	10
Mental health nurse/team	2	<1	17	<1	1	1
Psychiatrist	<1	<1	13	<1	1	1
Alcohol and drug worker	0	0	<1	0	6	6
Psychologist	0	0	3	0	0	<1
Aboriginal health worker	<1	<1	<1	<1	0	<1
Other	<1	0	<1	2	3	<1
Total	**100**	**100**	**100**	**100**	**100**	**100**

Notes
1. Excludes Western Australia, as they did not participate in the 2012 NPHDC.
2. Excludes Townsville Correctional Centre, as they did not provide complete Clinic and Medication data.
3. Totals include unknown health professionals.
4. Total for each health condition will not equal total 'problem managed' because more than 1 health professional could be consulted.

Source: Clinic form, 2012 NPHDC.

Table 4 examines the most commonly managed problems and whether a nurse or GP was consulted. Both medical practitioners and nurses deal with a wide variety of health conditions (Table 4). GPs were the most likely to consult about 'other' conditions that did not fit in existing categories (31%) and for general health assessments (16%). Nurses were most likely to deal with medication and vaccinations (25%), 'other' conditions (16%) and general health assessments (15%). Nurses also dealt with more cases of diabetes (8%), wound care (6%) and pathology (9%).

Table 4: Selected problems managed at prison clinic visits, by consultation with a nurse or medical practitioner, 2012

	Nurse		Medical practitioner	
	Number	%	Number	%
Medicine/vaccination	1,821	25	205	8
General health assessment	1,052	15	399	16
Pathology	684	9	135	6
Diabetes	603	8	63	3
Wound care	429	6	55	2
Alcohol or drug use	354	5	192	8
Psychological/mental health	348	5	187	8
Skin condition	250	3	198	8
Musculoskeletal injury	234	3	173	7
Dental	178	2	40	2
Smoking	47	1	4	0
Advice	21	0	1	0
Pain	18	0	11	0
Unknown	47	1	16	1
All	**7,234**	**100**	**2,436**	**100**

Notes
1. Excludes Western Australia, as they did not participate in the 2012 NPHDC.
2. Excludes Townsville Correctional Centre, as they did not provide complete Clinic and Medication data.
3. Totals will not sum due to the exclusion of additional 'problem managed' categories. See Table 2 for the full list of problems.

Source: Clinic form, 2012 NPHDC.

Medication prescribed in prison

On 1 day of the data collection period, every prescribed medication administered by the prison clinic was recorded, along with the demographic details of the prisoners taking the medication.

On that day, almost 22,000 prescribed medications were administered to about 9,000 prisoners (Table 5). This equates to around 4 out of 10 (37%) prisoners in custody, and females were more likely than males to be taking medication (55% and 37%, respectively). Antidepressants and mood stabilisers were the most common medication (16%), followed by analgesics (12%) and antipsychotics (9%).

Table 5: Prisoners in custody taking prescribed medication, by sex, 2012

	Male	Female	Total
Number of prisoners taking prescribed medication	8,004	888	9,027
Number of prescribed medications	18,672	2,733	21,766
Number of prisoners in custody on 30 June 2012	21,865	1,609	24,272
Proportion of prisoners taking prescribed medication (%)	37	55	37

Notes
1. Excludes Western Australia, as they did not participate in the 2012 NPHDC.
2. Excludes Townsville Correctional Centre, as they did not provide complete Clinic and Medication data.
3. Totals include 135 prisoners and 361 medication records where the sex of the prisoner was unknown.
4. The total numbers of male and female prisoners in custody are subject to rounding and randomisation and will therefore not sum to the total.

Source: Medication form, 2012 NPHDC.

The medications taken by prisoners varied with age as in the community. Prisoners aged over 45 were more likely than younger prisoners to be prescribed anti-hypertensives (19%), cholesterol-lowering drugs (14%) and drugs used in diabetes (7%). This is consistent with the associated health conditions more prominent among older people in the general population.

Non-Indigenous prisoners were more likely than Indigenous prisoners to be taking antidepressants (15% compared with 11%). Indigenous prisoners were slightly more likely to take anti-hypertensives (7% compared with 5%) and drugs used in diabetes (4% and 2%) when compared with non-Indigenous prisoners.

Medical appointments outside prison

Most primary health care services provided to prisoners occur within the prison clinic; however, some health conditions or specialised services require transfers to hospitals in the community. These transfers may be acute (emergency) or non-acute (planned). In 2012, there were 208 acute transfers and 359 non-acute transfers to hospitals during the 2-week data collection period.

Prison dischargees were asked if they visited a hospital emergency department during their time in prison. Just over 1 in 10 (12%), or 47, dischargees reported visiting the emergency department of a hospital during their time in prison. See the 'Introduction' for limitations of the dischargee data set.

Dischargees were also asked if they had a medical appointment outside prison during their incarceration. About one-fifth (22%) reported that they did have an appointment, including a similar proportion of males (22%) and females (21%), and Indigenous (21%) and non-Indigenous (23%) prisoners. Older prisoners were more likely than younger prisoners to go to an appointment outside prison. Just under half (46%) of prisoners aged 45 and over attended an appointment, compared with just 15% of those aged 18–24. This may reflect the more complex health concerns associated with age, length of time spent in prison and the service delivery model (the organisation of services between prison and the community).

The longer the duration that the dischargee had been in prison, the more likely it was that they attended any health service outside prison. Although 14% of those who had been in prison from 1 month to 6 months attended an appointment outside prison or attended hospital, about half (49%) of those who had been in prison from 1 to 2 years had done so.

This figure increased to about 4 out of 5 dischargees (82%) for those who had been imprisoned for 5 or more years. The overall number of dischargees in the collection was too low to further analyse the link between length of custody and attendance at health services outside prison. However, this could reflect the availability of health services in prison, and/or the chronic and complex health needs of the prisoners. This may also be a result of public waiting lists, because, in most jurisdictions, prisoners access public health services via the public waiting list. Just as for community members, the length of time a prisoner waits to be allocated an appointment for a public health services is based on their clinical need and the availability of services. Prisoners serving short sentences referred to public waiting lists who do not require immediate access to care are less likely to have 'moved up' the list in time to access services before their release from prison. It is hoped that in future data collections these issues may be able to be further investigated.

Referrals for further medical care

In all jurisdictions, prisoners entering prison receive a health assessment to identify their health needs. Following this, prison clinic health staff may refer prisoners on to further appointments with other health professionals, either within the prison or externally. About 2 in 5 (41%) prison dischargees reported that, following their reception health assessment, they were referred for a further appointment (Table 6). Females were slightly more likely than males to receive a referral at reception to prison (44% compared with 40%), while dischargees aged 25–34 and Indigenous dischargees were more likely to be referred (both 46%). Young dischargees aged 18–24 were the least likely to receive a referral (30%).

Table 6: Prison dischargees, received a referral, by sex, age and Indigenous status, 2012

	Referred for a further appointment		Was not referred for a further appointment		Unknown/did not receive a health assessment		Total	
	No.	%	No.	%	No.	%	No.	%
Sex								
Male	131	40	166	51	29	9	**326**	**100**
Female	27	44	28	46	6	10	**61**	**100**
Age group (years)								
18–24	25	30	51	61	8	10	**84**	**100**
25–34	68	46	66	45	14	9	**148**	**100**
35–44	38	42	44	48	9	10	**91**	**100**
45+	25	42	30	51	4	7	**59**	**100**
Indigenous status								
Indigenous	56	46	57	47	8	7	**121**	**100**
Non-Indigenous	101	39	132	51	27	10	**260**	**100**
Total	**158**	**41**	**194**	**50**	**35**	**9**	**387**	**100**

Notes
1. Excludes Western Australia, as they did not participate in the 2012 NPHDC.
2. Percentages do not sum to 100, due to unknown demographic information.

Source: Discharge form, 2012 NPHDC.

Treatment and diagnosis of health conditions in prison

The majority of prison dischargees who were diagnosed with the health conditions outlined in Table 7 were offered treatment while in prison. Health care for prisoners is provided as clinically appropriate. Notably, 91% of dischargees diagnosed with a mental health condition in prison were offered treatment, and all of the dischargees who reported being diagnosed with a respiratory condition in prison were offered treatment (Table 7).

Dischargees diagnosed with skin conditions, respiratory conditions and mental health conditions were commonly prescribed medication for treatment (86%, 80% and 73%, respectively). Not all health conditions require medication as part of a treatment plan. This should be considered when interpreting the data.

Table 7: Prison dischargees, offered treatment or prescribed medication for selected health conditions in prison, 2012

Health condition	Number diagnosed in prison	Percentage offered treatment	Percentage prescribed medication
Dental issues	68	87	43
Musculoskeletal injury	31	87	71
Skin condition	28	89	86
Psychological/mental health	22	91	73
Drug and alcohol issue	17	76	47
Sensory (including ear and eye condition)	15	87	67
Respiratory condition	10	100	80
Total	**260**	—	—

Note: Excludes Western Australia, as they did not participate in the 2012 NPHDC.

Source: Discharge form, 2012 NPHDC.

Health professionals available at prison clinics

The number of health care staff in a prison depends on factors such as whether the prison:

- is a reception centre—which generally include health assessments and therefore require more staff
- incarcerates females—which generally requires catering for a greater range and volume of medical needs
- requires drug and alcohol detoxification services
- has a rate of trauma and emergency incidents that may necessitate ongoing staffing
- has residential general health or mental health services—which require more intensive and ongoing staffing
- has services routinely provided in prison as opposed to through community services.

The time available to access prisoners, and the size and layout of the prison, may also have an impact upon service delivery and staffing numbers.

The number of full-time equivalent (FTE) health care staff also depends on the types of services offered within the prison system. In Victoria, for example, secondary and tertiary care and mental health services are offered outside of the prison clinic. Therefore, information about staffing for these services was not provided by Victoria as part of the data collection. As a result, staffing of prisoner health services in Victoria is under-represented.

Reporting on full-time staffing in prisons can be problematic for jurisdictions where there are complex governance arrangements in place for health staff (see 'Introduction' for details). For example, in some jurisdictions, contracted services are administrated according to the provision of particular health services, rather than providing particular staffing arrangements within the prison itself. For this reason, the available information on staffing of prison clinics may not accurately reflect total health staffing provided in the prison.

In 2012, there were 4.4 professionals per 100 prisoners across Australia (Table 8). Registered and enrolled nurses made up the majority of staff in prisons (4.0 FTE staff per 100 prisoners). Doctors and psychiatrists were the next most common employees. Data from Victoria are not available due to the way in which health services are contracted/purchased, and Western Australia did not participate in the 2012 data collection.

Table 8: Prison clinics, full-time equivalent staffing per 100 prisoners, states and territories, 2012

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Medical practitioner	0.13	n.a.	0.13	n.a.	0.24	0.41	0.74	0.21	0.15
Registered nurse	3.91	n.a.	3.35	n.a.	3.90	6.29	3.69	1.21	3.61
Enrolled nurse	0.51	n.a.	0.07	n.a.	1.01	—	—	0.07	0.39
Psychiatrist	0.19	n.a.	—	n.a.	—	—	0.37	0.07	0.10
Dentist	0.05	n.a.	—	n.a.	—	—	—	—	0.03
Aboriginal health worker	0.07	n.a.	0.02	n.a.	—	—	—	—	0.04
Psychologist	0.03	n.a.	—	n.a.	—	—	0.37	—	0.02
Nurse practitioner	0.02	n.a.	—	n.a.	—	—	—	—	0.01
Other	0.22	n.a.	0.04	n.a.	0.05	0.61	0.74	—	0.15
Total	**4.94**	**n.a.**	**3.60**	**n.a.**	**5.15**	**7.30**	**5.90**	**1.57**	**4.41**

n.a. not available

Notes

1. Excludes Western Australia, as they did not participate in the 2012 NPHDC.
2. Excludes Victoria due to unavailable data.
3. Not all health professionals are classified as full-time equivalent staffing at the prisons. For some jurisdictions, it may appear that some health professionals are not provided, but different funding models and service delivery modes may mean that this is not the case. Further explanation is provided in the next section, 'Health services information not previously available'.

Prison health services may receive visits from Aboriginal health services or have Indigenous health workers as members of their clinic staff to provide culturally appropriate care. Aboriginal Community Controlled Health Organisations (ACCHOs) are controlled by, and are accountable to, Indigenous people in the areas in which they operate. It is the aim of an ACCHO to deliver holistic, and comprehensive health care appropriate to the culture within the community that controls it (University of Melbourne 2011). An Aboriginal Medical Service (AMS) is a health service funded principally to provide services to Indigenous individuals. The most common types of health professionals are Aboriginal health workers and GPs.

Four out of 5 prisons (80%) did not receive any visits from an ACCHO or AMS. Those that did receive visits did not receive them very often—5 of these 14 Australian prisons received them less often than once per month.

ACCHO and AMS visits are one way of providing culturally appropriate health care services to Indigenous people in Australia. Where prisons did not receive visits from these services, arrangements may be in place, such as Aboriginal Health Worker positions, or other Indigenous health professionals being employed.

Health services information not previously available

As discussed in the 'Introduction', the governance structures, funding arrangements and mechanisms for service delivery in Australian prisons are complex and variable, both among and within jurisdictions; all 3 aspects can be provided by entirely different groups, including those employed under the Department of Health, Corrective Services or external contractors in the case of delivery of care. In particular, the delivery of prisoner health services in Victoria is unique. Victoria has a mix of public and privately operated prisons, and health services within these prisons are contracted by either Justice Health (public prisons) or Corrections Victoria (private prisons). However, Justice Health is responsible for clinical governance in both the public and private prisons. This complexity, both within and among jurisdictions, increases the difficulty of presenting a national picture of health services, both from a governance and data perspective.

Mental health services

The provision of mental health services to prisoners involves a particularly complex set of arrangements. For example, mental health services may be delivered by more than one provider simultaneously, for different purposes. In Tasmania, psychologists are contracted through the Correctional Prison Health Service, which is part of Forensic Mental Health in that state. Concurrently, psychologists are also contracted through therapeutic services by the Tasmanian Prison Service. In the Northern Territory, psychologists are provided on site by Corrections and psychiatrists and mental health services are provided on site by Health, while in South Australia, psychiatrists are funded by Forensic Mental Health and delivered by Health. In Victoria, psychiatrists, psychologists and mental health nurses, as well as GPs for some primary mental health services, are provided on site by health service providers contracted to Justice Health.

In Queensland, primary health services and mental health services are provided and funded by Queensland Health. Prison mental health services provide multidisciplinary in-reach services. The prison mental health service in Queensland is a state-wide service encompassing a number of local services located within the relevant Hospital and Health service. Queensland Corrective Services provide and fund psychologist services for assessment and input into risk assessment, and development of management plans to mitigate risk. This provides an opportunity to assess the environmental factors and appropriateness of placement. These complexities and variations among jurisdictions may mean that some mental health services in some jurisdictions are not currently captured in the NPHDC.

Alcohol and other drug (AOD) services

The provision of AOD services in Australian prisons also varies considerably among jurisdictions. Tasmanian prisons do not have access to alcohol and drug workers. In the ACT, alcohol and drug treatment services are provided by external contractors on site. In Victorian prisons, alcohol and drug treatment, in the form of programs and counselling, is provided on site through external contractors, and opioid substitution therapy programs are available on site at most prison clinics. In the Northern Territory, AOD treatment programs are provided by Corrections as part of their Prisoner Support Services; prison health services are able to refer prisoners to external AOD services provided by other branches of the Department of Health if required and the service is not provided internally. In Queensland, only the female centres offer opioid substation programs. There is no specialist AOD service that is provided into the prisons and work is currently being undertaken to fill this identified gap.

Dental services

Dental services may be provided either in the prison clinic or in the community. In South Australia, general and emergency dental care may be provided in either setting with funding from Health and provided by South Australia Dental Services or through local providers. In Queensland, dental services are provided in prison clinics within each Correctional Centre and are funded through Queensland Health and the associated Hospital and Health Services.

Services accessed in the general community

The NPHDC asks dischargees whether or not they were transferred temporarily outside the prison to access health services. This bulletin provides extra information regarding the types of health services accessed in the community.

Prisoner health services accessed in the community in the majority of jurisdictions include diagnostic imaging and procedures such as X-ray, pathology services, surgical procedures, and accident and emergency care. Some prisoners in New South Wales can access imaging and pathology collections on site. In Victoria, diagnostic imaging may also be performed within some prisons. In Queensland, pathology, simple surgical procedures and other investigations can be completed within the health centres. X-ray facilities were removed from centres across Queensland based on risks arising from radiation monitoring, maintenance of equipment and sustainability of a service with appropriately qualified staff. Transfers to community health services are required for all radiology, emergency or tertiary care.

Transfers outside prison are resource and time intensive, with Corrections staff required to escort the prisoner and remain with them until their return to prison. The costs and logistical difficulties of this must be balanced against the cost and logistical difficulties of providing the particular health services inside the prison grounds.

Which services are provided in prison and which require transfer to the community differ among jurisdictions. It may depend on the needs of the specific population. For example, in the Northern Territory, there are tuberculosis doctors and nurses to help with the

treatment and control of this communicable disease in prison, which is unique to this jurisdiction. The remoteness of prisons in the Northern Territory has led to an increase in the use of TeleHealth technology, and sourcing other in-reach services is another efficiency to minimise services that need to be provided within the community. Further, there is a planned and structured move to have hepatitis C treatment and clinics provided within the Northern Territory's prison health centres.

Returning to the community

For prisoners returning to the community, the resumption of chaotic lifestyles, unemployment and problems associated with accessing primary health services can lead to insufficient and uncoordinated care of multiple health conditions (AMA 2012). Health is a major factor in making the transition back to the community—unresolved health problems can undermine employment, education, housing and reuniting with family and friends. This has the potential to begin a cycle that leads to recidivism (Freudenberg 2004).

Connecting the provision of health care services in prison with those in the community often poses significant challenges. Prisoners should receive a discharge summary and up to 5 days of medication on release from prison to support them while they seek services from community providers. This can be logistically difficult with the high proportion of prisoners who are remandees (62% of prison entrants in the NPHDC) who may have unplanned exits from prison, such as those who leave following court appearances. Where possible, a GP should be identified to whom the discharge summary should be forwarded, and a copy provided to the prisoner and the point of discharge to facilitate the transfer of health information from prison into the community. However, there are a range of challenges for prison dischargees accessing community services. This includes finding an appropriate community clinician, ensuring that the clinician is based in the area in which the prisoner is returning to, and the prisoners' individual choice as to whether to attend a clinic for a medical appointment (both within prison pre-discharge and in the community to follow-up the patient on release).

Prisoners in Victoria with chronic health condition or complex health issues who are leaving prison have appointments made with community providers. Prisoners with an acute mental health disorder who have received residential mental health services in prison get intensive post-discharge follow up through the Community Integration Program. This program begins preparing prisoners for release from prison 6 weeks before release and continues 6 weeks post-release. Corrections Victoria also offers transition planning to support prisoners moving from prison to the community to find housing, accommodation and other support through the Transition Assistance Program.

In Queensland, Correctional Services and Health work closely together in respect to discharge, follow-up and supports within the community. Prison Mental Health Services provide a transfer of care to Community Mental Health Services. Any specialist appointments or outpatient clinics scheduled for the prisoner are included in the discharge summary. Other Queensland organisations provide bridging processes that aim to facilitate faster access to disability support and payments. Queensland Corrective Services provide rehabilitation officers who work with the individuals leading up to release to establish community links and support.

Poor treatment compliance may result from obstacles associated with the transition to the community and a range of health care providers (Levy 2005). If health care is not immediately available to prisoners upon their release, issues that may develop include: an increase in the community spread of infectious diseases; returning to substance abuse and the associated flow-on effects of infectious diseases and violence; untreated psychological conditions and consequences such as family conflict and community disorder; and family disruption, which can lead to unfulfilled parental responsibilities (Freudenberg 2004).

Returning to the community necessitates reapplying for a Medicare number, which is often a challenge and may become a barrier to health seeking (AMA 2012). For prisoners taking highly specialised medications in New South Wales, prison health services will apply for a Medicare number on their behalf and it will be given to the prisoner on release so they can immediately access their medication. Loss of Medicare benefits may lead to a delay in getting prescription drugs. With relatively high rates of communicable diseases and mental health disorders, many prisoners require medication to manage their conditions. Further to this, long waits to see health professionals may further discourage prisoners from following up treatment. Health discharge planning between prison health services and prisoners may help to overcome some of these difficulties.

Effective planning and management of a prisoner's reintegration back into the community, including continuity of health services, benefits both the prisoner and the community. Australian jurisdictions are responding by providing a variety of innovative programs and services that recognise the range of social, economic and personal challenges that may act as barriers to a successful return to the community. More research in this area will help to further inform policy and practice and overcome these challenges faced by Australian prisoners.

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