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Six health reforms

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Abstract

This article briefly examines six innovative justice solutions in the area of prisoner health.

Introduction

The next article in this issue ('Health in prisons') examines the issue of whether the level of health care for Victorian prisoners meets legal and treaty requirements (Russell 2021a). The State of Victoria was selected for that article because it has one of the best sets of statistics for prisoner health among the Australian States and Territories (so anything that is found wanting in Victoria is more likely to be an issue in other jurisdictions). The article concludes that required health standards are not being met in Victoria and that prisoner health is alarmingly poor. As will be discussed in the first article of the next issue ('The prison spiral'), prisons draw from the most disadvantaged sections of the community, and prison only magnifies that disadvantage. Inmates are exposed to an array of negative influences including criminalization, extortion, bullying, institutionalization, separation from family, reduced opportunities, derision, threats and trauma (Russell 2021b). Prisoners are 'an extraordinarily needy, unhealthy, and life-damaged cohort' (Deloitte Consulting 2003:1). 46% of released people in Australia return to prison within two years (54.9% return to corrective services, that is to prison or placed on community orders within two years) (SAC 2021), and the criminal culture, poor health and entrenched disadvantage tend to be passed on to the next generation (7:30 Report; Vinson 2007:vi-xv; Vinson and Rawsthorne 2015:24-36).

The first three reforms suggested in this article are discussed in the next article in this issue (on 'Health in Prisons').

Reform 1: Require greater transparency regarding prisoner health and healthcare

The next article in this issue ('Health in prisons') finds that government and non-government organisations with responsibility for the health of prisoners generally exhibited a serious lack of transparency with regard to their operations and finances. Rather than private prisons and healthcare providers being held accountable for the provision of adequate healthcare, there was actually very little information available to the public, and sometimes the excuse for insufficient information being provided was that these private organisations had commercial agreements with the government that were confidential. (Russell 2021a:11,12). The only groups privy to the private healthcare performance statistics were often the relevant government agencies such as Justice Health Victoria. This is an issue because it is against the interests of government agencies to release information on inadequate prison healthcare to the public.

For example, in Victoria, the Justice Health Quality Framework 2014 contains the minimum requirements for prisoner health and the Justice Health Performance Monitoring Program (for continuous improvement) yet both are unavailable to the public. In addition, Justice Health fails to publish statistics on medical staff employed within Corrections, although the sparse publicly available data indicates that the numbers of doctors, nurses, dentists and allied health professionals employed in prisons are far too low to provide the legally required level of healthcare (Russell 2021a). If prison health is to improve, government agencies will need to be held publicly accountable and be more transparent so that the government and providers of health and mental health services in prisons may be held to the same public scrutiny as other health services. Currently in Victoria, there is not just a lack of publicly available information, but there is a tendency to limit how much information is released to researchers and even a policy to require private health providers to limit how much information they release to the public in their annual reports (Forensicare 2016:12)

Reform 2: Employ more medical staff in prisons

Please refer to the next article in this issue ('Health in prisons') for a full discussion of the understaffing of prison clinics and the effect that this has on the level of health care provided and the ramifications of poor prisoner health.

Reform 3: Employ more correctional officers to enable improved healthcare

There are a number of aspects to this suggested reform. Firstly, supervising the prison clinic is one of the more difficult tasks for correctional officers. Prisoners become angry when sick or injured, especially if cooped up in an overcrowded room or cell while waiting a long period to see a health professional. It is usually a correctional officer rather than nurse who triages how quickly each prisoner sees medical staff, which is dangerous for the health of prisoners since the officer may not recognise a medical emergency. It also subjects the officer to significant abuse from frustrated patients. As a result, only a few officers in each prison are willing to supervise the clinic, often for the overtime involved. These officers are tired and at breaking point, which escalates tensions in the clinic (a dangerous place for tensions to exist with knives and needles present). Somehow, a larger pool of officers needs to be made available for the clinic. Secondly, more correctional officers are needed so that there are officers readily available to attend medical emergencies with medical staff. Prisoners have been dying because it took 20-30 minutes for a team to be assembled to attend a collapsed prisoner. Thirdly, adequate healthcare often requires the timely movement of prisoners with a medical condition, and this movement is often delayed due to inadequate staffing. This movement may include the officers needed to accompany a prisoner to hospital or simply to buzz the prisoner through all gates and doors leading to the clinic.

Reform 4: Treat those with a mental condition in a psychiatric hospital rather than prison

Secure psychiatric hospitals for prisoners are in extremely short supply throughout Australia. As a result, many prisoners suffering mental illness are confined to prison. Correctional officers are not psychiatric nurses and are not equipped for recognizing symptoms or responding appropriately. There is a far greater likelihood that prisoners acting uncontrollably due to mental illness will be violently subdued or punished rather than receiving psychiatric and/or medical attention. People with a mental illness are also more likely to harm themselves or others in ways that correctional officers may not expect (such as the common unprovoked attacks due to the urging of voices inside their heads, or

injecting themselves with their own faeces, which was a recent cause of death for an Indigenous inmate with a long-term mental condition).

Having mentally-ill prisoners in prison is contrary to their human rights because they are not receiving adequate health care. Instead, they are being given strong sedatives to make them docile. They are also being bullied and ostracized by other inmates because of their differences, inability to follow inmate-imposed rules or poorer hygiene.

Reform 5: Greater cooperation between prison health stakeholders

This is an area that has been improving, with greater cooperation between Departments responsible for areas such as Health, Corrections, Police, Aboriginal Affairs and Justice Health; and other stakeholders (such as local health districts, universities, specialty health networks, Aboriginal community health organisations, non-government organisations and community/advocacy groups). Positive effects of this improved cooperation have included more effective use of resources; setting and meeting larger targets such as providing better health and opportunities in disadvantaged postcodes; and more rapid adoption of improvements made in other jurisdictions. Further improvements in cooperation will bring even better outcomes for prisoner health.

Reform 6: Greater access to the proper medication

This is an area that has been improving, with greater cooperation between Departments

The issue here is that general society operates with zero tolerance to drugs and yet has adopted a harm minimisation policy with regard to needle exchanges. This harm minimization policy has been only slowly implemented within prisons. Correctional Services and unions for correctional officers have tended to resist the use of needle exchanges. However, technological solutions such as smart syringes already exist to avoid stabbings with a dirty needle, sharing of needles or making of knives, and they have been successfully used in some jurisdictions. Some sort of needle program is urgent because of the current needle-sharing, especially amongst Indigenous inmates (Ward et al. 2011:421). The fact that Justice Health is managed in Victoria as a supposedly independent unit within the Department of Justice and Community Safety may have a bearing on the slowness in health

reform. Prison health services in other States are managed by Justice Health and the Department of Health rather than within the Department of Justice (except for Western Australia where the Department of Corrective Services is responsible for Health) (AIHW 2012:6).

An important aspect of access to proper medication is the area of diabetes care. When a diabetic prisoner enters a prison or lockup, the insulin they came in with is usually confiscated (in case it is another type of drug). The prisoner needs to wait to see a doctor, receive confirmation from their outside doctor that they are indeed a diabetic, and then be prescribed a suitable dosage of tablets or short and/or long-acting insulin. Diabetic prisoners really need immediate insulin, but they often have to wait up to 5-7 days for the first dose. During this whole period, their bodies are being poisoned with a build-up of ketones leading to hyperglycaemia and ketoacidosis. Hospitalization is common in such circumstances and sometimes leads to the prisoner going into life-threatening dehydration and coma. Diabetic prisoners need to receive access to insulin on the day that they are incarcerated, which means that they must see a doctor or nurse upon arrival and receive the necessary insulin soon after that.

Prisoners are also at increased risk of blood sugar levels dipping to dangerous levels due to lack of food. Outside prison, they would normally carry a supply of jelly beans or similar to consume on such occasions. Inside, however, prisoners cannot always eat at the right time. They may be working or food may be delayed. Having a supply of jelly beans is not always easy. A cellmate could have eaten the sweets or new prisoners might not be able to get hold of jelly beans or other glucose supplies for a week or two. Prisoners in such predicaments often suffer hypoglycaemia and may again slip into a coma and potentially die. Purposeful issuing of glucose to diabetic prisoners, especially upon arrival, is essential.

Indigenous inmates who have a higher incidence of diabetes than non-Indigenous prisoners, are more likely to become ill or die from hyperglycaemic or hypoglycaemic incidents.

Another issue for diabetic prisoners is that they often find it difficult to get to the clinic at the right time to check their blood sugar levels and receive their insulin. This can seriously damage their health over time. Finally, inmates are unable to check their blood sugar level when they need to (for example, when their symptoms are telling them that they may have

a high or low blood sugar level). Not being able to test their blood at such times, means that they cannot take the proper preventative action until they have made it to the clinic. Rather than providing prisoners with multiple needles with which to test their blood when required, a possible solution could be to allow diabetic prisoners to use an attached glucose monitoring sensor that the prisoner could scan at any time and that is also connected to the clinic computers. Alarms can notify both the prisoner and the clinic if a life-threatening blood sugar level is being approached.

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