Prisoner Health in Victorian Prisons

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Abstract

This submission discusses whether the level of health care for Victorian prisoners meets legal and treaty requirements.

Advantages of improving prisoner health include: reductions in violence, recidivism, suffering and deaths in custody (including Indigenous deaths in custody); savings from reduced chronic diseases and complications; reduced spread of communicable diseases to other inmates and to the general community upon release; and better employment opportunities, both within and outside prison.

One interesting statistic that came out of the Guardian's analysis of all coronial inquests for Aboriginal deaths in custody was that 33 per cent of men and 50 per cent of women who died did not receive appropriate medical care (Gibson 2020). While (a) there may be other contributing factors for the death and (b) poor health may not have been the direct cause of the death, this statistic, serious as it is, may offer a possible avenue for reducing Aboriginal (and non-Aboriginal) death rates in custody by improving health. The possible link between health and death in prison certainly deserves more study as it offers hope of averting deaths through improved health.

Research into prisoner health in Victoria is, however, very difficult. It was found that publicly-available information on prisoner health in Victoria is severely limited. There is even some evidence that Justice Health's lack of transparency is at least partially intentional. It also appears likely that healthcare improvements are necessary to comply with existing legal and treaty obligations, and such improvements would certainly benefit prisoners and society generally given the current extremely poor level of prisoner health.

Legal requirements for prisoner health in Victoria

Justice Health claims qualified medical staff provide prisoners with the same standard of healthcare as the general population under the Victorian public health system (Corrections Victoria n.d.-b), and the *Standards for health services in Australian prisons* stipulates a comparable standard of care (RACGP 2011:2). This is a minimum standard under Rules 24,25,27 of the *UN Nelson Mandela Rules* (UNODC 2015) and is reflected in Principles 4.1.4,4.1.5,4.1.8 of the *Guiding Principles for Corrections in Australia* (CSAC 2018:20) which constitute goals rather than enforceable laws or standards. The *UN Bangkok Rules* provide additional requirements for women prisoners and their children given their greater vulnerability (UNODC 2010: Resolution, Annex, Rule 2).

Australia has also ratified the UN *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (UNCAT); and the UN *International Covenant on Civil and Political Rights* (ICCPR) (OHCHR 2021), both of which prohibit torture or 'cruel, inhuman or degrading treatment or punishment' (UNCAT:Art.2; ICCPR:Art.2). Torture would be rare in prisons, but rogue correctional officers or police have beaten, kicked, severely restrained, and endangered those in their custody (e.g. Coroners Court of Victoria 2021; AHRC 2000). In addition, Amnesty International regards inhumane prison conditions, solitary confinement, denial of medical treatment and severe mental and physical harm to amount to torture and other ill-treatment, giving Australia's 'offshore processing system' as an example (Amnesty International n.d.).

The *Guiding Principles for Corrections in Australia* (CSAC 2018:20) are intended goals rather than enforceable standards, and it is left to the States and Territories to develop their own laws and standards (CSAC 2018). The minimum requirements for Victorian prisons are contained in the *Correctional Management Standards for Men's Prisons in Victoria* (CV 2014a) and *Standards for the Management of Women Prisoners in Victoria* (CV 2014b). Whilst most parts of these standards provide relevant policies and legislation, this is not the case for the Health Services part, which only contains general information and refers to Justice Health. The Justice Health Quality Framework 2014 contains the minimum requirements for prisoner health and the Justice Health Performance Monitoring Program (for continuous improvement) (both unavailable to the public).

The *Commissioner's Requirements* also applies in Victoria (CV 2021a). It contains specific information to achieve consistency in limited areas and Part 5 deals with healthcare services (CV 2021b).

Finally, s. 47(1)(f) of the *Corrections Act 1986* (Vic) provides that every prisoner has the right to have access to reasonable medical care and treatment necessary for the preservation of health. Section 47(1)(g) provides the right for prisoners who are intellectually disabled or mentally ill to have reasonable access within the prison or, with the Governor's approval outside a prison to such special care and treatment as the medical officer considers necessary or desirable in the circumstances. There is also the right under s. 47(1)(h) to reasonable dental treatment necessary for the preservation of health.

Whether Justice Health's claims that prisoners are receiving the same level of healthcare as the outside population are justified is now examined. It is true that doctors, nurses and allied medical professionals are accessible by prisoners, but not so clear is whether there are sufficient numbers of each medical profession to see all prisoners. Whilst in theory one could say that prisoners have access to a doctor, the doctor for a prison is typically available one day each week, so only the worst cases can be examined each week. The remainder are turned away. When prisoners are turned away multiple times, some will become violent and others will give up, going undiagnosed and untreated. The disease or injury may then become far more serious, requiring greater medical attention and sometimes contributing to the death rate.

A major issue in comparing healthcare for prisoners with healthcare for the community is that Justice Health does not publish statistics on medical staff within Corrections. This is discussed later, but it means calculations can only be made on scraps of information revealed by rare reports on prison health.

Nurses and doctors in prisons

In 2011, the Victorian Ombudsman reported that the health provider at Barwon Prison received funding to extend nurse hours from about 154 hours/week to 224 hours/week. Despite that, the provider had been allocating 310 hours/week to keep up with demand, but was unable to afford that long term and the hours were cut again to 224 hours /week. They expressed concern that this caused 'a major disruption to the healthcare provided to the prisoners' (Brouwer 2011:30). This indicates Barwon Prison needed an extra 40% nursing hours to meet demand.

In 2011, Barwon Prison had an operational capacity of 425 prisoners (Department of Justice 2011:7). 224 hr/week represents 5.8947 FTE, which represents 13.1 nurses/1000 inmates. The ratio of nurses in the Victorian community is 16.67/1000 (see below), so an extra 3.57 nurses would need to be employed for Barwon Prison to match the outside level of nursing. This is an extra 21.6% (the discrepancy between 21.6% and 40% may be due to the extra medical attention that prisoners need due to their far worse health levels).

Nurses consistently told the Ombudsman more nursing hours were needed to provide an adequate standard of care (Brouwer 2011:29). The Ombudsman concluded, 'Medical amenities for prisoners are insufficient to meet the increasing needs of the expanding prison population and nursing hours need to be reflective of this increasing need' (Brouwer 2011:32).

Regarding doctors, Justice Health's then-Director estimated each initial medical assessment of a new prisoner should take 30-40 minutes for those with higher needs or 10 minutes for a young, fit person. Every doctor told the Ombudsman assessment should take 20-40 minutes per patient. Doctors however advised that 'due to time constraints, inadequate resources and the number of prisoners entering prison they often had to perform assessments within five to ten minutes.' Four times the number of doctors is therefore need to properly conduct assessments.

Doctors also said late arrivals were assessed over the phone while the doctor was at home.

Nearly one third of inmates were refusing to be transferred to hospital for procedures, mainly because they would lose their possessions, prison employment, place in programs and place in their cell while they were away, so they would need to start again. The Ombudsman recommended that the cell be preserved but the Department said this was impossible. The Department was therefore investigating another recommendation that specialists visit the prisons.

Doctors typically visit a prison of 300-400 inmates for a day each week and it takes three to four weeks to see a doctor (Deloitte 2003a:67). Taking the comment in Deloitte of 330 prisoners with the doctor in for 1 day, that means there is access to 0.2 doctors FTE for 330 inmates, which means 0.601 doctors/1000 inmates. This is less than 40% of the ratio of doctors in the Victorian community which is 1.62 doctors/1000 (refer calculations below).

The tables below show the number of nurses and doctors actively practising in Victoria in the general community. Those practitioners who are irrelevant to prisons (for example, midwives and sports doctors) have been excluded (refer assumptions beneath each table).

Practising Nurses		
	Victoria	Australia
Enrolled Nurses	22,890	72,341
Registered Nurses	85,336	337,816
EN & RN	3,750	9,885
Provisional Nurses	98	335
Total	112,074	420,377

Source: NMBA (2021:4)
Assumptions: Includes provisional nurses (since they also work in prisons), but excludes non-practising nurses and midwives (since nurses specializing as midwives are not employed by Justice Health)

Practising Doctors (see also Psychiatrists below)		
	Victoria	Australia
Total	16,275	65,560

Source: MBA (2021:4)
Assumptions: Includes only general practitioners and one-third of those that have both general and specialist registrations. Excludes all specialist practitioners (and two-thirds of those with have both general and specialist registrations). Excludes medical practitioners with limited or provisional registration types (because if they work in prisons, which is rare, they are supervised anyway). Excludes medical practitioners involved in teaching or research, and non-practising practitioners

The Australian population as at 15 May 2021 is 25,774,945 (ABS 2021) and the Victorian population was 6.681 million as at 30 Sept 2020 (ABS). Assuming growth of 0.625% in the 7.5 months to 15 May (growth was 0.7% in the previous year), the Victorian population as at 15 May 2021 is approximately 6,722,756 (ABS 2020a).

The ratio of the above medical professionals per 1000 general population is therefore:

Doctors/1000 and nurses/1000 of the general population		
	Victoria (Pop: 6,722,756)	**Australia** (Pop: 25,774,945)
Nurses	112,074 nurses = **16.67** nurses/1000 pop.	420,377 nurses = **16.31** nurses/1000 pop.
Doctors	10,868 doctors = **1.62** doctors/1000 pop.	44,840 doctors = **1.74** doctors/1000 pop.

Psychiatrists and psychologists in prisons

With regard to mental illness, it is telling that Justice Health does not claim that prisoners are receiving the same level of healthcare as the general population (CV n.d.-c), although they are still required to provide that level. The *Correctional Management Standards for Men's Prisons in Victoria* (2014) and the *Standards for the Management of Women Prisoners in Victoria* (2014) say the same thing about mental health services for Victorian prisoners: 'The prevalence of mental illness among prisoners means… demand for mental health services, in particular acute services, is high.' (CV 2014a:35.3; CV 2014b:35.3)

Almost one third of Victoria's male prisoners have diagnosed mental health conditions and the Victorian Ombudsman's investigation found the level of mental health services for the male prison population is 'grossly inadequate,' with insufficient beds in psychiatric wards for male prisoners and significant waiting lists (Brouwer 2011:5). The hospital reserved for certified prisoners under ss275,276 of the *Mental Health Act 2014* is Thomas Embling Hospital, with 136 beds. The number of beds has only increased by 20 since it was opened in 2001 (a 17% increase), but there were 2,500 Victorian prisoners at that time and now there are 8,046 (a 222% increase) (Forensicare 2016:3,6; CV 2021c). At any given time, there are ten certified prisoners waiting an average of 64 days to be admitted (Forensicare 2016:3,6).

Forensicare had 67 psychologists (48.96 EFT) in June 2020 (Forensicare 2020:52). Forensicare does some community work with potential offenders and covers mental health needs at seven Magistrates' Courts for Magistrates, court personnel, legal practitioners, court welfare services, disability services, forensic medical officers, custodial nurses, treatment agencies (including area mental health services), and police and prisons-based services (Forensicare n.d.:2).

Forensicare visits eight prisons and provides forensic mental health services at six prisons (Forensicare 2020:7). Assuming half of the psychologists (24.48) are allocated to prisoners,

and with the combined number of prisoners at these 14 prisons being 7817, there are 3.13 psychologists per 1000 inmates. This is nearly double the ratio in the community (1.66/1000), although the level and complexity of mental illness in prison is much higher.

40% of Victorian prisoners had been assessed as having a mental health condition, which was two to three times the rate in the general community (Glass 2015:6,34). This corresponded with a New South Wales study that was the first one in Australia to compare psychiatric illness amongst Australian prisoners with that of the general community. 80% of the prisoners had had psychiatric illness in the previous year compared with 31% of the general community (a factor of 2.5) (Butler et al. 2006:273). The Victorian Ombudsman stressed, 'the number of specialised mental health facilities in Victorian prisons are inadequate to meet the needs of prisoners with mental health issues. This results in an increased risk to the safety of the prisoner, staff and other prisoners" (Glass 2015:6). This included a much greater incidence of suicide, with 54% of prisoners had a history of suicide attempts or self-harm (McSherry and Carroll 2015).

The female prison system in Victoria provides a psychiatric bed for every 16 prisoners, but the male system only one bed for every 88 prisoners. Untreated mental health issues will affect the community when prisoners are released; it increases the likelihood of re-offending and compromises prison security. (Brouwer 2011:19).

With regard to psychiatrists, the Ombudsman calculated there were 1,585 male prisoners with a 'P' (psychotic) rating, but only 132 inmates could be seen each month (Brouwer 2011:18).

Practising Psychiatrists		
	Victoria	**Australia**
Total	1,188	4,303

Source: MBA (2021:8)
Assumptions: Includes only those with psychiatry registration

Practising Psychologists		
	Victoria	**Australia**
Total	11,165	39,776

Source: PBA (2021:4,6)
Assumptions: Includes provisional psychologists (since they also work in prisons), but excludes non-practising psychologists and a calculated estimate of the Victorian proportion of Australian psychologists specializing in educational, developmental, organisational, sport and exercise psychology (since they rarely practise in prisons)

Mental health practitioners/1000 of the general population		
	Victoria (Pop: 6,722,756)	**Australia** (Pop: 25,774,945)
Psychiatrists	1,188 psychiatrists = **0.18** psychiatrists/1000 pop.	4,303 psychiatrists = **0.17** psychiatrists/1000 pop.
Psychologists	11,165 psychologists = **1.66** psychologists/1000 pop.	39,776 psychologists = **1.54** psychologists/1000 pop.

Dentists in prisons

Certain groups in society, all of which are strongly represented in Victorian prisons, tend to have poorer oral health. Firstly, people living with mental illness are three times more likely to have no teeth and have on average 6 more decayed/missing/filled teeth than those without mental illness. People with intellectual disabilities also have poor oral health (COAG 2021:63, AIHW 2021a). Secondly, people from disadvantaged backgrounds including those in prison have double the rate of poor oral health compared with others (COAG 2021:50, AIHW 2021a). Thirdly, Aboriginal people aged over 15 experience tooth decay at three times the rate of non-Aboriginal people and are more than twice as likely to have advanced gum disease. Aboriginal people experience complete tooth loss at almost five times the rate of the non-Aboriginal people, and Aboriginal people are 1.8 times more likely to experience toothache (COAG 2021:55, AIHW 2021a). Osborn et al. (2003:37) also identify injecting drug and morphine use as risk factors for poor oral health. This 2001-02 NSW study, one of the first surveys of prisoner oral health in the world, indicated poor oral health in prisons and cited the latest statistic for dental attention as 2.5 full-time dentists covering 22 prison clinics and serving 7000 inmates in NSW.

That equate to 0.35 dentists per 1000 inmates, which is less than half the rate in the general community (0.8/1000). Considering the poor state of prisoners' teeth this is highly significant. Waiting times for a dentist can be 3-6 months, even when there is tooth ache (Deloitte Consulting 2003a:67)

Practising Dentists		
	Victoria	**Australia**
Total	5,350	22,678

Source: DBA (2021:4,5)
Assumptions: Includes general and both general and specialist dentists. Excludes specialist dentists and dentists with limited registration types (because if they work in prisons, which is rare, they are supervised anyway). Also excludes dental prosthetists (since this is generally not part of the service), dentists involved in teaching or research, and non-practising dentists

Dentists/1000 of the general population		
	Victoria (Pop: 6,722,756)	**Australia** (Pop: 25,774,945)
Dentists	5,350 dentists = **0.80** dentists/1000 pop.	22,678 dentists = **0.88** dentists/1000 pop.

Level of prisoner healthcare in Victoria

Every independent report on Victorian healthcare for prisoners reveals extremely unhealthy prisoners and a health service that is struggling to cope, particularly in the area of mental health. Even if prisoners had the same access to medical professionals as the outside community, that would still be inadequate because prisoners have far greater health needs. The AMA (2012) stated:

> As a group, prisoners and detainees have far greater health needs than the general population, with high levels of mental illness, chronic and communicable diseases, injury, poor dental health, and disability. Prisoners tend to be from disadvantaged backgrounds characterised by high levels of unemployment, low educational attainment, drug and alcohol addiction, insecure housing, and illiteracy and innumeracy.

The Victorian Prisoner Health Study also identified ten risk factors of prisoners that 'will not be satisfied by prison health services alone': higher levels of hepatitis A, B and C, exposure to all types of abuse, asthma, depression, insomnia, dental problems, STDs, hospitalisation, self-inflicted harm and suicide attempts (Deloitte Consulting 2003a:4).

AIHW (2020a) also notes that prisoners are generally more disadvantaged, with higher healthcare needs than the Australian population, concluding they need a high, rather than normal, level of care. For example, AIHW (2015) found Australian prisoners are twice as likely to be taking antidepressants or mood stabilizers, four times as likely to be taking medications for addictive disorders and nine times as likely to be taking antipsychotics. 65% of prison entrants reported using illicit drugs in the past year compared with 16% in the general community (AIHW 2018:96). Prison entrants were much more likely to have a history of injecting drugs than the general population (55% compared with 2%) (AIHW, 2010). In 2016, 58% of female prison entrants, and 44% of male entrants reported a recent history of injecting drug use. This health risk is exacerbated by the current reluctance of Corrections Victoria to introduce needle and syringe programs in prison (Voon et al. 2011).

The Victorian Prisoner Health Study described prisoners as 'an extraordinarily needy, unhealthy, and life-damaged cohort' (Deloitte Consulting 2003:1). The study goes on to differentiate between the level of healthcare inside and outside prison. The burden of the most significant diseases (cardiovascular disease, cancer, mental disorders and other chronic conditions and injuries) is described as 'small' in the general community because of ongoing prevention and treatment. Inside prisons, however, inmates are 'at the very high risk end of the Victorian health spectrum' (Deloitte Consulting 2003:1,2). In addition, the study notes inmate behaviours that entail significant risks to health: tattooing (which correlates with hepatitis C incidence); high drug, alcohol, prescription medicine and cigarette consumption; multiple sexual partners and unsafe sex; and compulsive gambling (Deloitte Consulting 2003:4).

Many other studies support the above reports regarding significant health and social disadvantage, including return to drug use, overdose and prison after release (Kirwan et al. 2019:406; Winter RJ 2016:104-111).

Mental health service provider in prisons, Forensicare, states, ‘Prisoners, as a group, have higher rates of mental illness and more complex clinical presentations across mental health and physical health than people in the general community. As such, prisoner health and mental health services need to be afforded a high degree of expertise’ (2016:9).

Barriers to improved prisoner health

There are, however, a number of barriers for advocates and researchers in prisoner health. With regard to the Legislature, there is the natural proclivity to weigh potential actions in terms of attracting votes and avoiding anything that could be embarrassing. Unfortunately, prisoner health, safety and living conditions do not rate highly on the political agenda, although as public policy it is in the public’s best interests.

If the time in prison were treated as an opportunity for restoring health, upon release there would be reduced anger, spreading of disease and strain on the health system; as well as improved confidence, ability to find work and inclination to stay out of prison.

The politicians contacted for this report appeared very cautious about any potential political agenda. They or their assistants asked questions to find out where I stood and I answered that I was deeply interested in the health of prisoners. A few offered to answer the questions posed, but there was no response despite follow-ups. This could be attributed to being very busy, but unfortunately the time spent on discovering where the researcher stood could have been used to answer the questions (10-15 minutes being needed).

With regard to Justice Health, my request for the FTE statistics of medical staff employed in Victorian prisons was refused because:

> In response to your request, I have sought direction regarding the release of contractual health service information and have been advised that the information that you have requested is classed as 'commercial in confidence' and not available for public release.
>
> As such I am unable to provide you with the requested information.
>
> Regards
>
> [Name withheld]
>
> Source: Email sent by Justice Health on 26 May 2021.

The fact that we have some private prisons and private health service providers, and that they have commercial interests, should not be a reason to refuse to provide basic statistical information to the public and researchers on a matter that concerns our society. Indeed, this data is so basic that it should be publicly available without the need to request it. If prison health is to improve, Justice Health will need to be held publicly accountable and be more transparent.

The Justice Health Quality Framework, which is the most important delineation of prison health standards in Victoria, is not publicly available. This researcher spent a very long time on the Internet looking for it in all the likely places, but finally found a recommendation by Forensicare that the prison health standards be made publicly available so that providers of health and mental health services in prisons could be held to the same public scrutiny as other health services. Forensicare, to its added credit, also called for the Justice and Health Departments to develop and publish a set of health service quality and safety indicators, and then for health services to report publicly on those indicators (Forensicare 2016:7,8,13). This is crucial. Justice Health's reticence can only be interpreted as not wanting prisoners, their families and reformers to compare the standards with the level of healthcare actually delivered. This negative interpretation is justified by something Forensicare said:

> In recent years there has been a continued policy direction by government to be more proscriptive about content of Annual Reports to the point that they do not necessarily provide a valuable medium for disseminating quality of care information.
> (Forensicare 2016:12)

Needless to say, this is inexcusable. The health service annual reports contain little useful information and it appears Justice Health asked for that to be the case. If an adequate quality of healthcare is being provided, there will be no need to cover up standards and outcomes. If private prisons or private health service providers wish to do business with the Victorian Government, it is submitted they should be required to be much more transparent with regard to number of employees, money and outcomes to ensure quality and avoid corruption (e.g. Australian 2005).

Conclusion

Whilst Victoria has good statistics compared to the other States for health services to the general community, Corrections Victoria and Justice Health need to dramatically improve the level of healthcare for prisoners to at least the level of community health services. Even then, the appalling health condition of prisoners requires not just equivalent healthcare for prisoners but greater investment in order to address the current prisoner health crisis. Greater investment in prisoner health is also essential because prisoners have to visit the clinic more often due to being unable to: (a) self-medicate as would have been possible had they been outside prison (AIHW 2012:8); (b) see medical staff on their first (or second) visit due to lack of staff; and (c) see a doctor without first seeing a nurse due to the nurse-led care model in prisons (AIHW 2012:2).

Greater cooperation between Departments (such as Health, Corrections, Police 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), as well as more rapid adoption of improvements made in other jurisdictions, could bring positive change in Victoria. For example, Victoria was the last State to introduce condoms in its prisons and there is currently a stalemate with a needle and syringe program. Corrections Victoria is presently against this program due to safety concerns for staff and inmates and because they have a zero tolerance for drugs inside prisons, whereas politicians have stated that they would be happy to see it introduced if it could be operated safely (Voon et al. 2011; see also Dugard 2006 for similar considerations in the ACT). 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. In addition, technological solutions such as smart syringes already exist to avoid stabbings with a dirty needle, sharing of needles or making of knives. The 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).

Improvement in health of inmates may be one of the most promising ways to reduce the rate of deaths in custody, including Aboriginal deaths in custody.

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