SUMMARY OF PROCEEDINGS FROM PRISONER HEALTH WORKSHOP

In early 2007 the National Health Committee (NHC) began a project on the health of New Zealand prisoners and their families. This project aims to outline strategic advice to the Minister of Health for minimising harm and improving the health of people in New Zealand's correctional facilities and other forms of custody, as well as the health of their families. To date, the NHC has conducted an international literature review on the health effects of imprisonment, a workshop on a health promoting prison system and numerous interviews with stakeholders in the field of Prisoners' Health.

Prisoners have poor health relative to the general population. Internationally, prisoner health is recognised as a complex issue that must be dealt with holistically and collaboratively. The overwhelming majority of the prison population is from groups with poor access to social and health services, and groups with multiple and varying health needs. The experience of incarceration itself can be harmful to the health of inmates and of their families. In many countries there has been a move to use the period of imprisonment to help address health issues rather than contribute to them.

On 7 September 2007 the NHC sponsored a workshop: "What would a health-promoting New Zealand prison system look like?" The day-long workshop featured a keynote address by Professor Michael Levy of ACT Corrections, expert speakers from around New Zealand and group workshops. It was attended by around 85 health professionals, officials from the Ministry of Health and Department of Corrections, prison employees, former inmates and their advocates. What follows is a summary of the proceedings; it does not necessarily reflect the opinion of the NHC, although the NHC Secretariat takes responsibility for any errors it may contain.

PANELS

We sought perspectives from former inmates themselves; from policymakers in Corrections, Public Health and Māori Health, and from clinicians and staff who implement prisoner health policy. Participants were asked to describe what must happen to create a health-promoting prison system.

Former inmates said there is a persistent need for major shifts in attitude and culture among prison staff and the public. Prisons must be seen as rehabilitative, not merely punitive. The delivery of good health care must become a top priority within the Corrections establishment. A "professional attitude and non-judgemental delivery of health care to prisoners" was called for. Some examples of practical suggestions from this group were:

- Psychological support when it is needed, not just toward the end of the sentence.
- Ensuring that behaviour modification techniques do not exacerbate mental or emotional instability. We heard the story of 19 year old girl who was 'troubled' and progressively deprived of the things she valued most, as part of the prison's correctional policy. Her experience of corrections

officers was unpredictable (some were nice, some vindictive). She eventually killed herself in isolation.
- Ensuring that literacy is not a prerequisite for obtaining medical attention.
- Inmates would be allowed to teach one another. The NHC heard of one inmate who was a qualified adult literacy teacher, but was forbidden to teach her fellow prisoners to read.
- Ensuring appropriate responses to normal emotional disturbance. We heard that women in one particular facility were considered "at risk" if they cried, regardless of the reason, and were threatened with or removed to isolation.

The Committee heard from former inmates who had difficulty obtaining medication while in prison and from others who had difficulty obtaining their own medical records after their release. These reports highlight the importance of the recent work of the Prison Service to align health care with health sector standards, and of monitoring the implementation of the new practice standards.

Former prisoners wished to redress the imbalance between research and experience, expressing the benefit of including first-hand experience in development of prisoner health policy. This would mean involving former inmates in policy development, systems design and implementation planning. There was also support for additional in-community residential AOD programmes, particularly those guided by members of the former-inmate and former-drug-using community. ("We know what works and what doesn't work.")

This group called upon policymakers to address prisoner health holistically, by treating the physical, emotional, spiritual and intellectual dimensions of health and wellbeing. Additionally, they voiced the need to treat prisoners with unfailing dignity, humanity and compassion, regardless of their crime. This signalled a range of improvements such as:

- consistent access to health care and resources for prisoners
- appropriate health staff selection and training
- improved dental care
- improved eye care
- strengthened mental health care for women.

Former inmates urged that policy be developed with an awareness that many communities regard the health system with the same suspicion as the correctional system. One participant made a statement that shocked many in the audience. The man, who had recently had a medical emergency, said, "For me, anything to do with medical is money. So I waited until the last minute and I was nearly dead, so I have to go, and I was more worried about how much it was going to cost me. I didn't know it was free, I didn't know you go to the hospital, it comes out free. So how many other people think that same way. When you look at inmates, they think the same way, they don't know a lot and a lot of it's really communication, that's how I see it."

Communication and engagement, both with inmates and with the community (communities hosting former prisoners often include many other groups with

high health needs), must improve to ensure people do not, as the speaker did, risk their lives because of a mistaken belief that hospital care costs money.

The same speaker pointed out that encouraging more frequent and complete communication between inmates and their families will, in itself, improve their respective health and he emphasised the link between the inmate's family's access to care and the inmate's own wellbeing. "If the families are good, so are the inmates in the prison, and they'll handle what's dished out to them as long as they know the wife and kids are safe and there's support there for them."

We heard from one speaker that restorative justice principles and practice should be a part of reintegrating prisoners into their families and their communities, a sentiment that was later echoed in some of the workshops.

From the *policymaking* perspective there were strategic observations and practical suggestions. One speaker urged New Zealanders to examine why we incarcerate and ensure that, when it is necessary to do so, we limit the damage to inmates and to society. Incarceration should be viewed as a societal failure, not as a success.

Restricting our efforts to making prisons 'health promoting,' said one participant, mistakenly puts the emphasis on the institution and risks normalising our growing incarceration rates. We must look first at root causes for the determinants of imprisonment, which are similar to the determinants of poor health. There is also a need for a deep change in the culture and functioning of prisons.

There are many opportunities on the way to prison for the health system (and other sectors) to intervene and potentially prevent later imprisonment. Many people cycle through prison because they don't get the help they need outside or inside prison.

A range of recommendations included:

- better education for people about their rights to health care in the community, improved access, and resources committed to assisting the same person repeatedly if necessary
- the focus on health in prisons being on Māori, as improvements for them will improve the situation for others
- emphasis on the promotion of mental health in prison
- using the inequalities intervention framework to develop health policy and structures for prisoners, and looking separately at different population groups while doing so.

The point was made that the Ministry of Health sets out health policy, not the Department of Corrections. Corrections must facilitate, but does not control the resource levels or (some) service delivery, for drug treatment or mental health services. Inmates' needs also go well beyond primary care (the responsibility of Corrections). For this speaker, collaborative policy setting is not the hard part - the hard part for Department of Corrections is implementing the policy in areas in which it holds neither responsibility nor authority.

Operational and Clinical perspectives ranged from social critique to specific operational advice.

According to one speaker, health should be promoted in prisons, but we must not allow ‘healthy’ and ‘health-promoting’ to become adjectives for prison. To do so would indulge our desire to believe we are improving the situation without taking active steps to reduce the growing prison population. The main causes of growing numbers in prison are social conditions and attitudes, and penal policies arising from them. The trend reinforces the notion that the public has a right to be protected, and that that is the foremost or only purpose of imprisonment. But by this logic, even confining those ‘at risk’ of offending could be construed as a public health initiative.

Community attitudes reflected in the media are a major barrier to delivering care effectively and professionally. As a society, we ought to actually care for inmates rather than put them, and their problems, ‘away.’ In addition to being unjust, this creates unfair expectations of and burdens upon prison health staff.

As health professionals, said another speaker, poor care can result from our attitudes. If we see inmates as victims and ourselves as rescuers, we can get trapped into game playing. Or we can belittle them and come off smug and superior. It can be very challenging to maintain a sense that ‘I’m ok, and you’re ok’ and yet this attitude is essential to deliver effective care. Those who wish to change process and culture within the prison environment will continue to be stymied until this process is understood.

Prisoners often have low expectations for good health care and therefore don’t seek or receive it. Even after being released from prison, this group is found to have high levels of untreated morbidity and poor to no access to primary care. This is for reasons such as GP shortages, cost of treatment, perceived cost of treatment, and unfamiliarity or a sense of uneasiness with the health care system. Rehabilitation requires that people can see hope for, and make and implement decisions toward, a better life. This includes but is not limited to health, restorative justice, family and personal capacity and expression. Better integration of, and communication among, the relevant agencies (Health, Corrections, Housing, Education, Social Development, etc) is needed to improve the reintegration pathway.

It is often not appropriate to imprison people with addictions or with personality disorders. Often, people with addictions used drugs to cope with past trauma and/or anxiety, physical pain, uncontrolled anger or depression. Treating addiction in these cases means we must address the long term problem.

Recommendations included:

- A prison health service should be run like any other health service, for instance: patient notes should be sought from the practice and discharge notes should be sent; treatment plans are changed only if it is to benefit the patient; the service undertakes strategic planning to

address significant issues, not just react to them. (For example, assault, infections, disease surveillance and treatment, addiction management, etc).

- It must be assertive, as many prisoners have low self-esteem and may accept neglect. It must include screening (not active requests for testing or the judgement of staff), and has to follow through from such screening.
- It should link inmates to their families and to health services in the community.
- Improvement to prison health services should be governed by Māori.
- All service changes should be auditable so progress can be shown.
- Prisons are encouraged to work with prisoners using a 'person development' approach (incorporating common humanity, identity, personal capacity, capability, and opportunity).
- The prison health service must nevertheless avoid over-promising, as health interventions cannot solve most of the problems arising from broader social conditions.

WORKSHOPS

Workshop groups were asked what they would put in place to create a health-promoting prison system in four areas of health care. Many of the ideas that emerged were similar across two or more groups.

Personal Health as part of Taha Tinana

The main conclusions from the Personal Health group were:

- The only way to involve patients (including inmates) in receiving primary care or screening services is to involve them in the design process. Service providers need to recognise the leadership that exists within both the prison community and their families, and enable them to exercise that leadership toward achieving a first class health service.

- Length of stay should be a key consideration when planning the delivery of personal health services. However, length of stay should not be used to gate-keep, as was the case when an inmate with an oral abscess was not treated because there were only four weeks until release. The transferral of inmates between prisons is another factor which makes it hard to build relationships with health workers and meet the real needs of the prisoner. Inmates who are in health, addiction or other programmes should not be transferred away mid-programme.

- Needs Assessments should extend beyond health, should be culturally appropriate, should be clearly for the benefit of the patient, and patient care plans should be developed. For the sake of consistency, the same screening tools should be used in all prisons, but Māori mental health needs should be assessed by appropriate people. Access to family in general should be improved. Where a patient care plan has already been developed, that plan should travel with the patient into the

prison system and back out again. Upon release, there is a need for more resources, including improving programme availability.

Support was shown for more specialist units, such as the faith-based unit, to serve particular needs. A mentoring system and more and more accessible counselling services within prison were also favoured. Some within the group thought that both Health and Corrections staff need to be made aware of the programmes, the goals of the programmes, and the mental health care individual prisoners are undergoing (information which is not currently shared).

The group also contributed some observations about principles underpinning personal health for prisoners. These included the notion that Corrections staff have a security kaupapa, and therefore are not the right people to provide a caring health service. The Treaty principles of Partnership, Participation and Protection should underpin programme and assessment development - in particular there is still a need for more Māori employed across the whole prison system. Principles of restorative justice should underpin policy and programme development.

Continuity of Care as part of Taha Whānau

This group contributed the following insights:

- Health care in and out of prisons should be person-centred. Care should be provided for mental and physical health needs, not solely to address criminogenic needs. The health system, and more specifically the system ensuring continuity of care, must have a rehabilitative focus. The system must enable easy access to a wide range of services including, but not limited to, health.

- There is an opportunity for a Māori solution in prisoner health, but such responsibility must be accompanied by adequate authority. The patient journey model should be developed by Māori.

- Continuity of care is in place but needs to be better coordinated. Agencies should be collaborating prior to the release of the inmate. Service design must take into account and plan for the impact on whānau, so that any preventive or health promotion gains within prison accompany the inmate home to their partners and children. Former inmates themselves should be involved in health promotion in the community.

- It is important to ensure that the operational constraints of prisons do not compromise inmate health, access to health care or continuity of care. Once, needs assessments were primarily to minimise risks to the institution, not to assess prisoners' needs. But practice is changing and the four new correctional facilities: Northland Region, Spring Hill, Auckland Region Women's, and Otago Region, are designed, in architecture, systems, and language, to encourage culture change from within. It would be useful for providers to work together with prison

officers to challenge transfers of prisoners taking place as a result of mustering pressures. An example of a holistic measure with positive health outcomes for prisoner and whānau is a family reception centre backed by progressive visiting policies (seen in Western Australia).

- The Department of Corrections is driven by a mission statement identifying a single purpose for its work: the wellness and wellbeing of people. If responsibility for health is moved outside of Corrections, Corrections must not divorce itself from prisoner health. It is essential that the services remain integrated.

Mental Health and AOD as part of Taha Hinengaro
Much of the feedback from the group looking at mental health care and AOD was about issues that cut across all kinds of care.

Many families of inmates share the same mental health or AOD problems. The opportunity (of imprisonment) should be taken to improve access to all types of health services for ex-prisoners and their families. The gaps in services inside prison, including more and better access to counselling, and outside prison (cf Effective Interventions mental health/AOD work), must be filled. More advocacy and information services were also called for.

The group thought that the moment of re-entry is a key moment. Investment in support for this moment of the prisoner journey should be increased. Restorative justice principles should guide the reintegration process (with family and community). The group complained that transferring prisoners between prisons undermines health and health care, and wanted to see prisoners remain near their families.

The new mental health screening tool shows a lot of promise, but all screening tools should be locally developed, culturally appropriate, and administered by culturally competent staff. Nationally accepted gambling and AOD screening tools should be put in place.

The group wished to see adequate needs assessments conducted at the outset of each sentence. Some believed that who does the assessment, for whom and for what, is very important, because prisoners will not reveal personal or sensitive information if the context is not right. Another person believed health staff lines of accountability are not the issue, but that a new mental health unit is needed to accommodate patients beyond the capacity of the forensic units.

Information sharing and communication was a theme. Agents throughout the health sector, including PHOs and GPs, need to be linked with the Department of Corrections. Information links should be determined in light of the disparate purpose of the two sectors and the purpose the data will serve. Participants said that AOD information collected for the courts should be transferred to prison if the offender is convicted. As AOD programmes in prison are run by Corrections but Forensic services are with Health, communication and information sharing could be improved.

The group thought the prison health care model should be person-centred and that more input from health professionals into management level corrections policymaking is needed. Inmates need to build a relationship with a doctor in a mentoring based programme. Prison doctors and nurses could learn to approach their patients in a similar manner to the Faith-based specialist unit – that is, clinical, psychological and spiritual.

Staff development and support was another theme for this group. Prison staff needed better personal and professional development opportunities and better supervision.

The group expressed the opinion that in prison, shame is instilled and respect is removed. Mana needs to be protected or restored for Māori inmates. When a man goes to prison he relinquishes all responsibility as a father. This is playing havoc within families. Dislocation from whānau is a big problem.

The Treaty of Waitangi principles should be observed and those relationships engaged. There need to be more Māori working across the whole system, more Māori mental health care, and Māori mental health assessments should be conducted by appropriate people.

Public Health as part of Taha Wairua

The Public Health group suggested that it may be necessary to send a message to the public that imprisonment does not remove the right to health care. There may be an argument for legislating human rights for prisoners, to make them explicit.

There is a big gap between health policy and practice in prisons. There needs to be an independent voice, not connected to the custodial infrastructure, to act as a watchdog and to advocate for improvements in health service delivery for inmates. An advantage of the 'Healthy Prison' model is that it will help shift the culture in prisons because it imposes a new way of thinking and forces the institution to systematically examine the way in which it operates.

The screening process is not well informed; there are significant disincentives to answering some questions. Participants thought that information should be distributed in a relevant and timely manner, not in a flood at admission, and the onus for conveying information about health services should be on the staff as well as the inmate.

A number of public health-related concerns were highlighted, including

- Social support systems for inmates are devastated by visiting rules, for instance former inmates can't visit for two years.
- Dyslexia, illiteracy and other learning disabilities need to be identified early.
- Condom access is difficult and in-prison stigma is a barrier.
- Health kits/harm minimisation kits should be implemented everywhere.

The group suggested we consider alternative philosophies; for instance a prison model from Spain which acknowledges the permeability of the prison perimeter. This model has apparently led to successful health outcomes.

FINAL THOUGHTS

Some participants shared final thoughts:

- The critical public health issue is incarceration itself. We must look hard at the reasons for imprisonment and we must reverse the normalisation of incarceration.
- Health fits poorly within a punitive framework: Health care must shift toward the Health sector, away from the Department of Corrections. For many reasons, it is not possible for a custodial service to provide therapeutic care: the paradigms are too different. The reasons include:
    - patients must fully trust their provider to open up in order for therapeutic interventions to be effective
    - the skills and resources required for a rehabilitative orientation are not to be found within the prison service. Prison health service's base and accountabilities must be outside it
    - health professionals must be protected to make independent decisions
    - community participation is necessary to promote good inmate health and continuity of care.
- The Effective Interventions pilots show promise for preventing some inappropriate incarcerations.
- Research and evaluation are critical parts of this work, to ensure that policies have the desired results, and to help counter the vocal misinformed.
- The Department of Corrections is not responsible for who is convicted or sentenced to prison, and will need many helpers to bring practice into line with aspiration.
- More Māori are working for the Department of Corrections now, and there have been big shifts in attitude within the department around such things as punishment, wellbeing and whānau connection. Prisoner treatment is not the same as it was ten years ago. There are also large numbers of volunteers visiting prisoners.
- There are simple, working solutions to some problems. There are solutions within Māoridom if we can support their use.
- Prison can be, and already is in many cases, a chance for health improvement, but good work done by Corrections staff is frequently undone when the prisoner is released, due to poor continuity of care planning or barriers to access to care in the community.
- Prisoners are fathers, mothers, brothers and sisters who will return and hopefully make a contribution to society. Their health care is correctly part of a wider debate on criminal justice issues. It is essential that people with firsthand experience be actively drawn into and involved in any decisions and processes for policymaking.
- This dialogue is appropriate and necessary in order to destigmatise and promote the culture change we seek. Interest in this topic is growing, and particularly now, prisoners need to give more and more accounts of their real experiences.