National Health Committee

Hunga Kaititiro i te Hauora o te Tangata

Health in Justice

Kia Piki te Ora, Kia Tika!

Improving the health of prisoners and their families and whānau

He whakapiki i te ora o ngā mauhere me ō rātou whānau

The National Advisory Committee on Health and Disability (National Health Committee – NHC) would like to thank the many individuals and organisations that contributed valuable ideas and information to this project. In particular, the committee values the input of prisoners and their families and whānau who shared their experiences so generously.

The NHC also thanks the secretariat for their work, and in particular, that of Liza Wilcox (project manager) and Catherine McCullough.

Members of the NHC who contributed to this project were:

2010

- Pauline Barnett (NHC Chair)
- Te Kani Kingi (lead project sponsor)
- Maaka Tibble (project sponsor)
- Robin Kearns (project sponsor)
- Phil Shoemack (project sponsor
- Dale Bramley (project sponsor)
- Sheila Williams
- William Taylor
- Kitty Chiu

2007–2009

- Linda Holloway
  (NHC Chair until September 2009)
- Api Talemaitoga (former lead project sponsor)
- Karleen Edwards (former lead project sponsor)
- Lynette Stewart (former project sponsor)
- Carmel Peteru
- Geoff Fougere
- Gwen Tepania-Palmer
- Riripeti Haretuku

Citation: National Health Committee. 2010. *Health in Justice: Kia Piki te Ora, Kia Tika! – Improving the health of prisoners and their families and whānau: He whakapiki i te ora o ngā mauhere me ō rātou whānau*. Wellington: Ministry of Health.

Published in July 2010 by the
Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

ISBN: 978-0-478-36604-4 (online)
HP 5133

This document is available on the National Health Committee website:
http://www.nhc.health.govt.nz

National Health Committee
Hunga Kaititiro i te Hauora o te Tangata

No-one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens but its lowest ones.
Nelson Mandela

Remember those who are in prison,
as though you were in prison with them.
Hebrews 13: 3

Contents

List of Tables

List of Figures

Message from the Chair

The National Health Committee's (NHC's) investigation into the health of prisoners and their families and whānau has challenged many of our assumptions about the nature of incarceration and its relationship to the health of the wider community.

Although we, as a society, tend to believe otherwise, prisoners are part of the wider New Zealand community. They come from and return to our communities – often staying in prison only briefly – and their poor health has implications for all of us. Returning people to their children and communities with poor or worsening health is not in anyone's interest and only adds to demands on the health system, offending rates, and our growing prison population.

As beds and buildings are added to our prison system, waiting lists grow for addiction and mental health services; yet there is no shortage of evidence to demonstrate that there are ways to increase investment in health and addiction treatment that improve health outcomes and reduce offending.

Prison is an opportunity to protect, promote, and improve the health of prisoners and the community. But the NHC has found that the experience of imprisonment has negative health effects on those incarcerated and unintended consequences for the health and well-being of their family and whānau. Furthermore, the health effects of imprisonment fall most heavily on already disadvantaged communities – further undermining their resilience and increasing inequalities. It is a tragedy that Māori make up half the prison population. There are significant consequences for whānau ora and hauora Māori overall.

From our consultations and the evidence we have compiled it is clear considerable benefits can be gained by developing closer ties between prison health services and the health sector. In New Zealand, most specialist health services for prisoners are the responsibility of the health sector, but primary health care is provided by the Department of Corrections. The NHC has come to the view that the role of the Department of Corrections in community safety, that of custody and containment, is inconsistent with the demands of contemporary, integrated primary health care. Our findings have raised the question of whether any agency charged with custody can or should be a health provider.

To improve prisoner health and the health of their families and whānau, three important steps are necessary. The first step is to provide significant additional investment in services so the health of prisoners, their families and whānau, and the wider community can be improved. The second step is to make a series of improvements to protect against the negative effects of incarceration and improve health delivery. The third, and most important, step is to consider the strong case for transferring responsibility for prison primary health care from the Department of Corrections to the health sector. In other comparable states, prison health services are now part of the health sector rather than the corrections sector. These jurisdictions report significant improvements in the quality of health care and health outcomes as a result.

The health, economic, and social costs of not investing in health services for prisoners are high. The information we have gathered not only shows us that change is needed, but has also convinced us that change is possible.

The NHC believes we, as a country, have a responsibility to those we imprison and to their children and families. The benefits will accrue to our whole society and to future generations, but so too will the costs if we fail to take action.

Pauline Barnett
Chair, National Health Committee

Summary

Context for the report

The National Health Committee (NHC) has been investigating the health of prisoners and their families and whānau since 2007. As the Government's work on Addressing the Drivers of Crime has recognised, crime in New Zealand is the result of complex mix of social and individual factors. Health problems play a significant role.

The poor health of prisoners not only contributes to their offending but has negative health, social, and economic impacts for all New Zealanders, particularly prisoners' families and whānau. These adverse effects fall most heavily on already disadvantaged communities and increase health inequalities.

New Zealand evidence is broadly consistent with evidence from other developed countries. Prisoners typically score poorly on measures of mental health, alcohol and other drug use, oral health, chronic disease, communicable disease, disability, injury, and health risk and protective factors (particularly factors related to living in poverty).[1]

The genesis of poor prisoner health is complex, but is connected to the health of prisoners' communities of origin. The evidence suggests the community setting is paramount in the development of the health of prisoners; particularly during critical periods of physical and neurological development. However, the evidence also highlights that imprisonment contributes significantly to poor health outcomes. The more time an individual spends in prison, the greater this contribution.

The NHC acknowledges the important and difficult role the Department of Corrections and law enforcement agencies play in community safety. In casting light on the environment of prisons, the NHC is not questioning their existence, but highlighting the physical and social conditions that corrode the health and wellbeing of those detained.

This report draws on the information the NHC gathered during prison visits and discussions with people who have the most experience of and expertise in prison health services. The NHC also carried out an extensive literature review and commissioned research to better understand the health needs of the families of prisoners.[2]

Conclusions of the National Health Committee

Imprisonment is the removal of a person's liberty. Punishment should not include poor health or poor access to health care, yet prisoners disproportionately experience poor health and their health needs are not adequately addressed either in prison or in the wider community. A custodial approach that prioritises behavioural risk management over clinical need is an ineffective response to prisoners' health problems. The experiences of other countries show that it is possible to protect and promote prisoners' health without compromising public safety.

The NHC is calling for a change in the delivery of health services to prisoners. The NHC recommends that the transfer of prison health services from the corrections sector to the health sector be investigated further.

Health is the core business of the health sector, so it is better placed to provide high-quality, comprehensive health services, especially to high-needs patients. The Department of Corrections is responsible for the safe containment and management of prisoners and for many prisoners is the first contact with health services. The Department of Corrections is, in effect, the health provider to people with the highest and most complex needs. If New Zealand is to manage the escalating health needs and costs that the growing and ageing prison population presents, it must focus on prevention, high-quality care, and rehabilitation. New Zealand must take a therapeutic approach to the health and disability needs of prisoners.

Health professionals working in correctional settings need appropriate support, protections, training, and accountabilities. This is increasingly supported by experiences overseas.

Health services to prisoners need to focus on early identification and assessment, rather than being primarily reactive to incidents of injury or disease. Family and whānau need to be involved in setting goals, care planning, adding to prisoners' motivation for change, and ensuring prisoners maintain relationships and carry out family responsibilities.

Prisoners' records about diagnoses, treatments, and other health matters need to be transferred with prisoners in a timely manner when prisoners enter, transfer between, and leave prisons.

People leaving prison need active referrals to ensure they and their families and whānau can access appropriate treatment and recovery options.

These changes will have positive, flow-on effects for the whole community.

Health of prisoners is a critical problem for New Zealand

The families of many prisoners are often under significant financial and relationship stress before the arrest occurs; health problems only exacerbate the already dire situation of these families. The poor health of prisoners reflects the level of need in some of New Zealand's poorest and most deprived communities. The deteriorating health of families or communities often increases the risk of imprisonment for its members. This situation contributes to New Zealand's crime rates and worsening health outcomes for the country as a whole.

Prisoners are a high health-need group

New Zealand's most comprehensive study of mental health among the prisoner population found lifetime psychotic, mood, or anxiety disorders among 52 percent of prisoners. Twenty percent were 'thinking a lot about suicide' and nearly 60 percent had a mild to severe personality disorder.[3] Eighty-nine percent of prisoners had a lifetime prevalence of substance abuse.[4]

In the 2005 Prisoner Health Survey, 67 percent of responding prisoners smoked daily and 46 percent reported tooth or mouth discomfort while eating or drinking within the previous four weeks. Sixty-four percent had experienced at least one head injury - 73.6 percent of Māori men. Almost ten percent of men in prison reported heart disease, and 35 percent of women in prison reported having asthma. Nearly 46 percent of women and 28.4 percent of men reported one of the communicable diseases or parasites listed in the survey.[5]

More than half of prisoners had no qualifications, 18 percent reported difficulty learning, and only 45 percent were in paid work before they were imprisoned. Twenty-three percent reported visual difficulty and 31 percent reported difficulty hearing.

Although New Zealand lacks prisoner-specific evidence of its own, local data highlights the link between victimisation and offending[6] and international studies show high rates of previous physical, emotional, and/or sexual abuse within prison populations, particularly for female prisoners. A New South Wales study found that 60 percent of female and 37 percent of male prisoners had been sexually abused before they turned 16.[7]

Drivers of crime and determinants of poor health are related

The drivers of crime and the determinants of poor health have much in common. Many among the prison population grew up in settings in which risks to health and development were numerous and protective factors were limited: homes and neighbourhoods shaped by poverty, exploitation, and violence. The prison population's disproportionate exposure to these factors has a strong influence on their health and their futures.

New Zealand's most serious and recidivist offenders tend to be those with the greatest concentration of health and social problems. This group makes up a small proportion of those who commit crime, but is responsible for most crime and most violent offences.[8] If these health problems are not properly addressed, their influence on health and offending tends to accumulate, and agencies can find it harder to respond to people's needs.

Health issues such as addiction are also associated with lower-level and repeat offending and contribute to New Zealand's yearly prison 'turnover' and growing imprisonment rates.

Poor prisoner health is likely to increase health and criminal justice costs

It is likely to be less expensive overall for both the health system and the criminal justice system to identify and address prisoner health needs at the earliest possible point. To not do so results in rising long-term costs to the health and criminal justice sectors.

Some of New Zealand's current investment priorities are counterproductive. For example, expenditure to achieve one aim sometimes undermines another (eg, at-risk units are intended to prevent suicide in prisons but often worsen prisoners' mental health).

System fragmentation is another problem. As New Zealand's resources are split between agencies with different aims and priorities, service gaps are built into the system and people cannot help but fall through. For example, someone who is identified as a current drug user in prison is excluded from corrections-funded treatment for their addiction because they have broken the rules of conduct (ie, taken drugs).[9] However, a released prisoner with addiction problems who has followed the rules and not used drugs in prison is not prioritised for treatment after release because their clinical need ranks lower than the level of need that available resources can address. Service gaps increase costs to both the individual and the state. Health issues are more likely to worsen and accumulate the longer they remain unaddressed.

Former prisoners represent one of the highest-cost population groups to the health sector. When people are incarcerated, an opportunity exists to reduce these flow-on costs by maximising the effectiveness of primary health care and other services.

Poor health also increases costs to the justice sector. Despite health not being the core business of agencies such as the New Zealand Police, the courts, and the Department of Corrections these agencies spend valuable resources[10] responding to people with serious and unaddressed health concerns. For example, in 2008, police responded to almost 10,000 incidents involving people with mental health problems.[11]

Significant health expenditure arises from crime. The cost of treating victims is estimated at more than $400 million each year.[12] The health sector has a significant role in responding to the effects of crime, so has a vested interest in reducing crime and victimisation.

Imprisonment has negative health effects

Prisons are inherently stressful and non-therapeutic environments. They exacerbate prisoners' existing health problems and can introduce new health problems. Opportunities for people to protect and improve their own health in prison are limited. Security concerns mean basic measures such as flossing teeth and taking vitamins cannot be carried out.

Risks to prisoners' physical and mental health are significant. These risks arise from of all aspects of prison life: the physical environment, the prison culture, and the behaviours people develop to survive prison. The more time people spend in prison, the more likely their mental and physical status will deteriorate.

Poor prisoner health affects families, whānau, and communities

If left untreated, prisoners' health problems constitute a significant threat to the health of their families and whānau and the health of the wider community. The most obvious example is communicable disease. New Zealand's prisons contribute to the prevalence of diseases such as tuberculosis.[13]

The high rate of untreated alcohol and other drug addiction among prisoners has long-term health effects for the prisoner, increases the likelihood of family members developing addictions and children developing health problems, contributes to family violence and unhealthy lifestyles, and is a major contributor to offending.

It is estimated that at any one time about 20,000 New Zealand children will have at least one parent in prison.[14] A growing body of evidence suggests that having an incarcerated parent increases the risk of poor health for these children.[15] Children of prisoners are also more likely than their peers to become part of New Zealand's future prison population. Longitudinal studies suggest that young people whose health is not protected and promoted during critical stages of their development are at an increased risk of poor lifelong health outcomes and are much more likely to become serious, violent, and recidivist offenders.[16]

Improve prisoner health to benefit the community

The NHC believes that improving the health of prisoners and their families and whānau will reduce the likelihood of health-related reoffending, and so benefit the whole community. To achieve this, changes are needed to the principles underpinning prisoner health care, planning, the responsibility for prison primary health care, cross-agency relationships, and service delivery.

As responsibility and funding for prisoner health is distributed among several agencies, these recommendations propose actions for agencies both within and external to the health and disability sector. Some recommendations relate to specific services the Department of Corrections currently provides. Most recommendations require the justice and health sectors to work together, often with the participation of other relevant agencies.

Adhere to principles to guide prison primary health care

To improve primary health care and disability support services in prisons, the sector needs to adhere to the following six principles.

Adhere to the principle of 'equivalence of care based on needs'

The principle of equivalence of care when delivering health services is an international standard for prisoner health. This principle is enshrined in New Zealand law. It reflects the fact that in civilised countries punishment (through imprisonment) is a sentence to a loss of liberty not to physical harm or poor health. This principle asserts that prisoners should receive the same level and standard of health care as they would receive if they were not in prison but had the same level of need.

Align health care services in prisons with health legislation

To realise the principle of equivalence of care based on needs, the legislation that applies to health and disability services outside prison needs also to apply to services provided to prisoners. Health care for prisoners needs to be aligned with the purpose and objectives of the New Zealand Public Health and Disability Act 2000 and meet the standards of the Code of Health and Disability Services Consumers' Rights.

Ensure principles of Whānau Ora drive policies and procedures

Applying Whānau Ora principles means engaging with whānau, hapū, and iwi, recognising and building on existing capabilities and strengths within families, and coordinating and integrating services to support whānau aspirations. Having a family member in prison can be an opportunity for the whānau and prisoner to develop mutual goals. When whānau build relationships, skills, and resilience, they also build their capacity to break cycles of criminal behaviour and to mitigate the intergenerational impacts of offending and imprisonment. To improve health and wellbeing and reduce reoffending, policies and procedures that affect prisoners should be driven by the principles of Whānau Ora.

Take a prevention and care (therapeutic) approach

A therapeutic approach sees health conditions as problems to be identified and treated, both by right (because of the state's inherent duty of care) and as part of the rehabilitation process. This approach means placing priority on prevention and care rather than on control and punishment.

Implement health-promoting prison policies and practices

A health-promoting approach actively minimises the harms of imprisonment and improves the safety and the health and wellbeing of everyone living and working in prisons. Such an approach builds the health and resilience of prisoners and staff and respects the dignity of every person in the prison. This approach can be achieved only with a whole-of-prison and a joint-agency focus on improving the physical, social, and institutional environments of prisons.

Involve prisoners in designing prison health and disability support services

People with first-hand experience need to be actively drawn into and involved in policy-making, service design, and service delivery. Meaningful patient involvement in decisions about their health and design of services provides a foundation for effective and high quality health

systems. It is also a cornerstone of the Better, Sooner, More Convenient vision for the health system, which stresses patient-centred design and delivery of care and empowering people (and whānau) to be in control of their own health and to make informed choices.[17]

Recommendations

The NHC recommends to the Minister of Health that to improve the health of prisoners and their families:

1 Agencies providing health services and disability support to prisoners:
   - a adhere to the principle of 'equivalence of care based on needs' to ensure prisoners receive the same standard of care in relation to their needs as is available in the wider community
   - b align health care services in prisons with existing health legislation
   - c ensure policies and procedures affecting prisoners are driven by the principles of Whānau Ora
   - d take a prevention and care approach to prisoners' health conditions and disabilities (therapeutic approach)
   - e implement health-promoting prison policies and practices
   - f involve prisoners and, where possible, their families and whānau in designing prison health and disability support services.

(See section 7.)

Improve planning

To improve delivery of health and disability services to prisoners, government agencies must undertake the following.

Consider potential effects of policy on prisoners and their families and whānau

Any public policies with the potential to affect prisoners, families, staff, or visitors should be assessed for their potential health effects on prisoners and their families and whānau before they are implemented. This assessment will ensure positive health effects can be enhanced and negative effects can be eliminated or mitigated.

Report regularly on the health and disability status of the prison population

The agency responsible for primary health services in prisons needs to report regularly on the health and disability status of the prison population. This is required to ensure workforce and service planning is relevant to the health needs of the population being served.

Ensure service delivery can meet the prison population's needs

Service planning is fundamental to any high-quality health care system, and it should be based on the best information available about health and disability needs, projections, and current service deficiencies. Government agencies responsible for the health and disability needs of

prison populations should cooperate to ensure service delivery is adequate to meet the identified needs of the prison population, particularly in the areas of oral health, mental health and alcohol and other drug dependence and addiction.

Recommendations

The NHC recommends to the Minister of Health that to improve the health of prisoners and their families:

2 Government agencies, when proposing new policies that may affect the health of prisoners, staff, families, or visitors, are required to consider the potential effects on the health and wellbeing of prisoners and their families and whānau.

3 The agency responsible for primary health services in prisons regularly reports on the health and disability status of the prison population and uses these reports to ensure service delivery is adequate to meet the identified needs of the prison population.

(See sections 8 and 9.2.)

Strengthen relationships and address responsibility for primary health care

The NHC believes prisoner health can be improved by reconsidering the responsibility for prison primary health services and strengthening cross-agency arrangements.

Address responsibility for prison primary health services

Consideration of a transfer of accountability for prisoner primary health services from the Department of Corrections to the Ministry of Health is the key recommendation of this report. Transferring primary health care services will ensure the health sector is responsible for all health services delivered to prisoners.

The NHC is concerned that the Department of Corrections' fundamental role as the 'custodian' of prisoners, which focuses on safe restraint and risk management, conflicts with the department's role as a health provider. The health sector is better equipped to oversee and deliver appropriate levels of health care and disability support.

Several overseas jurisdictions have realigned accountability to match core state service roles. Primary, secondary, tertiary, and mental health care in prisons is governed by the state health agency in England and Wales, France, Norway, New South Wales, South Australia, Queensland, Northern Territory and Tasmania.

When the health care of prisoners has shifted to the state health agency and the roles of health and custody have been separated and clarified, outcomes have improved demonstrably. It is not always possible to establish causal connections between institutional change and specific outcomes, but the NHC's overall impression is of substantive improvements, including:

- a better understanding of the health needs within the prison population
- stronger links between health services in prisons and health services in the community
- an improved standard of care provided to prisoners
- improved recruitment and retention of health care staff for the prison population.

Significant benefits are likely from transferring the funding and management of primary health care in prisons from the Department of Corrections to the Ministry of Health. The NHC recommends that the feasibility, benefits, costs, and other implications of such a transfer are further investigated.

Recommendation

To align accountability for prisoner health with accountability for the health of the general population, the NHC recommends to the Minister of Health that:

4 The Minister of Health directs officials to investigate the feasibility, benefits, cost, and other implications of transferring responsibility for policy development, funding, and oversight of the provision of primary health care for prisoners from the Department of Corrections to the Ministry of Health and the National Health Board.

(See section 10.2.)

Strengthen cross-agency arrangements

Realising the principle of equivalence of care based on needs requires leadership from both the Ministry of Health and the Department of Corrections and a commitment from all levels of the health and corrections systems.

Good cross-agency arrangements would involve regular meetings among the chief executives of the Ministry of Health, the Ministry of Justice, and the Department of Corrections to ensure:

- the effective monitoring and review of health and disability services for prisoners
- agencies work together to achieve the best outcomes for prisoners and their family and whānau
- the establishment of health-promoting prison policies and practices.

To ensure the needs of all prisoners (and concerns relating to their families) are addressed, chief executives from other relevant agencies (eg, Te Puni Kōkiri and the Ministries of Pacific Island Affairs, Social Development, Women's Affairs, and Youth Development) should also be part of the regular meetings. Interdepartmental working groups among senior officials will be needed to carry out activities resulting from these meetings.

The Ministry of Health, in collaboration with the Department of Corrections, is best placed to develop a new framework for the delivery of health and disability services to prisoners. The purpose of the framework is to reinforce the alignment of the prison health system with the

non-prison health system and strengthen the emphasis on health services for prisoners in both systems. Input from other organisations should be sought as appropriate.

Recommendations

The NHC recommends to the Minister of Health that to align accountability for prisoner health with accountability for the health of the general population:

5 The chief executives of the Ministries of Health and Justice, the Department of Corrections, and other relevant agencies (eg, Te Puni Kōkiri) meet regularly to:
   a ensure the effective monitoring and review of health and disability services for prisoners
   b identify how agencies can work together to improve outcomes for prisoners and their families and whānau
   c lead the establishment of health-promoting prison policies and practices.

6 The terms of reference of the HANZOFF and HANZON joint departmental working groups are widened to include prison practices that affect the health of prisoners, including health-promoting prison action plans in each prison.

7 The Ministry of Health leads, in collaboration with the Department of Corrections, the development of a new framework for the delivery of health and disability services to prisoners and seeks input from other government agencies and non-governmental organisations as appropriate.

(See section 10.1.)

Strengthen service delivery

To improve service delivery the agency responsible for primary health care services in prisons needs to improve the quality of that care; strengthen the identification, assessment, and treatment of health conditions and disability support needs of prisoners; and ensure the seamless continuity of health care as prisoners move into, between, and out of prisons.

Improve quality of primary health care and disability support services

Although the Department of Corrections has attempted to address inadequate primary health care in prisons, the delivery of *equivalent* prison health services remains challenging. Services are provided in an environment dominated by a focus on security, health staff practise in a highly challenging environment, continuity of care is frequently compromised, and prisoners cannot choose their health care providers (eg, a Māori provider).

However, opportunities exist in the short term to strengthen existing practice and improve the quality of prison health services. To improve the quality of prison primary health care and disability support services, the agency responsible needs to undertake the following activities.

Advance development of multidisciplinary primary health care teams

The high and complex health and rehabilitation needs of the prison population demand a variety of skills and specialties. A multidisciplinary health care team can provide this variety across the prison system. Multidisciplinary teams will ensure the right skills are brought to bear, professional support is strengthened, and health workers better understand their patients' needs.

Develop professional development programme for prison health workforce

All prison health professionals require strong orientation, clinical support, institutional protections, support for professional development, and options for mentoring or supervision to prevent unsafe practice. The prison nurse workforce has a broad scope of practice and a high degree of autonomy. Although prison nurses have a core training programme, they need ongoing professional development (eg, to identify, understand, and respond to the health and disability conditions and associated behaviours prevalent in prisons and to manage risk in the practice environment).

Support prison health staff to establish and join clinical networks

Prison health staff require professional and collegial support to deal with the difficulties inherent in prison practice and the ethical dilemmas they regularly face. Prison nurses may feel isolated in the nursing workforce and its professional organisations and associations. General practitioners and other health workers have no formal support for clinical networking within the prison system. All prison health professionals should have the opportunity to participate in nationwide prison clinical networks and in local clinical networks.

Strengthen the quality assurance framework

A quality assurance framework is essential to ensure continuous quality improvement. A prison primary health quality assurance framework needs to include accreditation (to improve service quality and establish credibility), independent audit (to ensure prison health service providers are audited in a similar manner to other health services), monitoring and evaluation (to monitor outcomes and review the appropriateness and effectiveness of services), and clinical pathways for common conditions (to improve service quality and consistency).

Ensure prison health services collect and analyse the same health status and service measures as other providers

The corrections health service maintains an electronic record for each prisoner, but most of the data expected from primary health care agencies reporting in the community is not recorded reliably or not collated or analysed nationally. Therefore, this information is not available for service planning, funding bids, monitoring, performance improvement, research purposes or to track performance against Government health targets. Prison health services need to collect and analyse the same health status and service measures as primary health care providers in community settings.

Recommendations

The NHC recommends to the Minister of Health that to improve the quality of prison primary health care and disability support services:

8 The agency responsible for primary health and disability support services in prisons:
   a advances the development of multidisciplinary primary health care teams
   b develops a continuing professional development programme for the prison health workforce
   c supports prison health staff to:
      i establish clinical networks for all health professionals who work in prisons
      ii join regional clinical networks with colleagues who work outside prisons
   d strengthens the quality assurance framework to closely align it with the frameworks used by other primary health care providers
   e ensures prison health services collect and analyse the same health status and service measures as primary health care providers in community settings.

(See section 9.1.)

Strengthen the identification, assessment, and treatment of health conditions and disability support needs for prisoners

The corrections health service responds successfully to acute injuries and many communicable diseases. However, it lacks *systematic* identification, assessment, and treatment services. Problems are particularly notable in the areas of mental health, alcohol and other drug misuse, and oral health.

Prisoners are about three times more likely than the general population to require access to specialist mental health. However, no systematic mental health screening occurs in prisons and insufficient capacity exists for treating those diagnosed with problems.

A lack of alcohol and other drug assessments and treatment for prisoners undermines community safety. An estimated 2,000 prisoners with substance abuse problems are released from prison each year without an alcohol and other drug assessment.

Good dental health services can detect early signs of nutritional deficiencies and immune disorders. Poor oral health is associated with a number of serious health conditions including cardiovascular disease. The national procedures guiding prison dental services allow a limited set of treatments for prisoners detained for one year or more and who have shown 'previous dental responsibility'. This criteria precludes access to clinically appropriate treatment for people who need it most and widens existing health inequalities.

To strengthen the identification, assessment, and treatment of health conditions and disability support needs of prisoners, the agency with responsibility for primary health and disability support services to prisoners needs to undertake the following activities.

Conduct an initial health and disability assessment for prisoners

Health assessments when a person enters prison should focus on health needs, not on what facilities are available or only 'criminogenic'[18] needs. Full assessments would enable a clear plan for treatment and support to be developed. Health and disability referral decision tools and assessments should be subject to ongoing expert clinical oversight, monitoring, evaluation, and improvement.

Work with other funders and providers to ensure service delivery is adequate to meet identified needs

The agency responsible for primary health care to prisoners is responsible for adequate service planning to meet the future primary health care needs of the prison population. This agency is also responsible for providing the data required to assess the need for additional services it may not oversee, such as secondary care and forensic and community mental health and alcohol and drug services.

Additional capacity is needed in primary mental health care for prisoners, forensic and specialist mental health care for prisoners, primary and secondary alcohol and other drug treatment for prisoners, and community treatment options for mental health, addiction and dependence, intellectual disability or brain damage, and personality disorder. Additional step-down and transition facilities and services are also required. Government agencies need to work together to address this shortfall in services. Oral health services to prisoners also need to be reviewed.

Improved treatment for prisoners with these health needs will help to reduce health inequalities, improve family and community health outcomes, and reduce reoffending.

Train staff to identify prevalent health conditions and impairments

Prison officers, along with health staff and others in regular contact with prisoners, play an important role in the early identification of health conditions and hidden disabilities. Prison staff need training to identify the health conditions and disabilities common among prisoners. Such conditions and disabilities include mental illness (including personality disorder), suicide risk, alcohol and other drug addiction and dependence, intellectual disability, brain injury, and visual and hearing impairments.

Recommendations

The NHC recommends to the Minister of Health that to strengthen the identification, assessment, and treatment of health conditions and disability support needs of prisoners:

9 The agency with responsibility for primary health and disability support services in prisons:
   a conducts a health and disability assessment for each prisoner when they enter prison
   b works with other funders and providers to ensure service delivery is adequate to meet the needs identified in the prison entry and subsequent assessments

c provides appropriate training to prison officers, health staff, and those in regular contact with prisoners to enable them to identify health conditions and impairments that are prevalent among prisoners.

(See section 9.2.)

Improve continuity of health care and disability support when prisoners enter, transfer between, and leave prisons

Seamless continuity of care is critical for improved reintegration and rehabilitation outcomes. Successful reintegration practice builds on the strengths of prisoners and their families and whānau and helps to overcome vulnerabilities such as addiction and poor health. This reduces the risk of reoffending.

The agency responsible for primary health and disability support services in prisons needs to ensure seamless continuity of care, including:

- the timely transfer of health-related information on a prisoner's entry to, transfer between, and release from prison
- beginning to plan for the prisoner's release needs at the first health assessment, with family or whānau participation if possible
- ensuring uninterrupted medication regimes on a prisoner's entry to prison, transfer between prisons, and release
- prisoners having contact with support workers before and after their release from prison
- active referral to community providers when prisoners are prepared for release
- the accessibility of appropriate service options including Māori providers, Pacific providers and Whānau Ora practitioners
- follow up with released prisoners who have health or disability support needs shortly after their release from prison
- serious consideration of health and support needs of prisoners when an inter-prison transfer is being considered.

Recommendations

The NHC recommends to the Minister of Health that to improve the continuity of health care and disability support when prisoners enter, transfer between, and leave prisons:

10 The agency responsible for primary health and disability support services in prisons takes responsibility for ensuring seamless continuity of care, including:
   a the timely transfer of health-related information into, between and out of prison
   b in preparation for release from prison, active referral to community providers
   c using Whānau Ora principles to guide continuity of care.

11 The health and support needs of the prisoner are given serious consideration when an inter-prison transfer is being considered.

(See section 9.3.)

Protect and promote the health of family and whānau of prisoners

While in prison, most prisoners remain members of family, whānau, and communities. These are the people prisoners tend to turn to for help and support during their sentence and are likely to return to when their sentence ends. Families and whānau are affected by the incarceration of a family member; imprisonment often has a negative impact on family finances, health, and relationships. Children of prisoners are likely to experience negative physical, emotional, and mental health effects.[19]

The state has a responsibility to ensure that its processes do not adversely affect the health and wellbeing of family members, particularly children. This includes improving communication and information sharing with family members and incorporating prisoners' family responsibilities into sentencing plans. In addition, appropriate services need to be available to address the health-related problems of family members. This begins with assisting non-governmental organisations, Māori providers, and Pacific providers to support released prisoners and their families and whānau.

Those making and implementing policies relating to prisoners need to recognise that most prisoners are part of wider caring and support networks that continue to operate while prisoners are in prison; often at significant cost to those involved. Whānau ora can be both positively and negatively influenced by the imprisonment of any whānau member, both during the sentence and after release. A Whānau Ora approach to prisoners and their whānau will support successful health and social outcomes and help prisoners to reintegrate with their families and communities on release.

Recommendations

The NHC recommends to the Minister of Health that to protect, promote, and improve the health of family and whānau of prisoners:

12 The Department of Corrections, as it reviews its policies:

- a identifies ways to encourage greater communication between family and whānau members and prisoners
- b integrates prisoners' family and whānau strengths, responsibilities, relationships and aspirations into prisoner sentencing and reintegration plans.

13 Government agencies identify how they can best assist non-governmental organisations, Māori providers, Pacific providers, and faith-based groups that provide support to released prisoners and to the family and whānau of prisoners.

(See sections 11–13.)

Recommendations

The NHC is making 13 recommendations about how to improve the health of prisoners and their families and whānau. Responsibility and funding for prisoner health is distributed among several agencies, so these recommendations propose actions for agencies both within and external to the health and disability sector. Some recommendations relate to specific services the Department of Corrections currently provides. Most recommendations require the justice and health sectors to work together, often with the participation of other relevant agencies.

The NHC recommends to the Minister of Health that:

To improve the health of prisoners and their families

Principles

1 Agencies providing health services and disability support to prisoners:

- a adhere to the principle of equivalence of care based on needs to ensure prisoners receive the same standard of care in relation to their needs as is available in the wider community
- b align health care services in prisons with existing health legislation
- c ensure policies and procedures affecting prisoners are driven by the principles of Whānau Ora
- d take a prevention and care approach to prisoners' health conditions and disabilities (therapeutic approach)
- e implement health-promoting prison policies and practices
- f involve prisoners and, where possible, their families and whānau in designing prison health and disability support services.

(See section 7.)

Planning

2 Government agencies, when proposing new policies that may affect the health of prisoners, staff, families or visitors, are required to consider the potential effects on their health and wellbeing.

3 The agency responsible for primary health services in prisons regularly reports on the health and disability status of the prison population, and uses these reports to ensure service delivery is adequate to meet the identified needs of the prison population.

(See sections 8 and 9.2.)

To align accountability for prisoner health with accountability for the health of the general population

Responsibility for primary health care

4 The Minister of Health directs officials to investigate the feasibility, benefits, cost, and other implications of transferring responsibility for policy development, funding, and oversight of the provision of primary health care for prisoners from the Department of Corrections to the Ministry of Health and the National Health Board.

(See section 10.2.)

Cross-agency arrangements

5 The Chief Executives of the Ministries of Health and Justice, Department of Corrections and other relevant government agencies (eg, Te Puni Kōkiri) meet regularly to:

- a ensure effective monitoring and review of health and disability services for prisoners
- b identify how agencies can work together to improve outcomes for prisoners and their families and whānau
- c lead the establishment of health-promoting prison policies and practices.

6 The terms of reference of the HANZOFF and HANZON joint departmental working groups are widened to include prison practices that affect the health of prisoners, including health-promoting prison action plans in each prison.

7 The Ministry of Health leads, in partnership with the Department of Corrections, the development of a new framework for the delivery of health and disability services to prisoners and seeks input from other government agencies and non-governmental organisations as appropriate.

(See section 10.1.)

To improve the quality of prison primary health care and disability support services

8 The agency responsible for primary health and disability support services in prisons:

- a advances the development of multidisciplinary primary health care teams in prison
- b develops a continuing professional development programme for the prison health workforce
- c supports prison health staff to:
  - i establish clinical networks for all health professionals who work in prisons
  - ii join regional clinical networks with colleagues who work outside prisons

d strengthens the quality assurance framework to closely align it with the frameworks used by other primary health care providers

e ensures prison health services collect and analyse the same health status and service measures as primary health care providers in community settings.

(See section 9.1.)

To strengthen the identification, assessment, and treatment of health conditions and disability support needs of prisoners

9 The agency with responsibility for primary health and disability support services in prisons:

a conducts health and disability assessments for each prisoner when they enter prison

b works with other funders and providers to ensure service delivery is adequate to meet the needs identified in the prison entry, and subsequent, assessments

c provides appropriate training to prison officers, health staff and those in regular contact with prisoners, to enable them to identify health conditions and impairments that are prevalent among prisoners.

(See section 9.2.)

To improve the continuity of health care and disability support when prisoners enter, transfer between, and leave prisons

10 The agency responsible for primary health and disability support services in prisons takes responsibility for ensuring seamless continuity of care, including:

a the timely transfer of health-related information into, between and out of prisons

b in preparation for release from prison, active referral to community providers

c using Whānau Ora principles to guide continuity of care.

11 The health and support needs of the prisoner are given serious consideration when an inter-prison transfer is being considered.

(See section 9.3.)

To protect, promote, and improve the health of family and whānau of prisoners

12 The Department of Corrections, as it reviews its policies:

- a identifies ways to encourage greater communication between family and whānau members and prisoners
- b integrates prisoners' family and whānau responsibilities and relationships into prisoner sentencing and reintegration plans.

13 Government agencies identify how they can best assist non-governmental organisations, Māori providers, Pacific providers, and faith-based groups that provide support to released prisoners and to the family and whānau of prisoners.

(See sections 11–13.)

1 About this Report

The National Health Committee (NHC) began examining the health of prisoners and their families and whānau in 2007. The NHC was concerned that the body of international research and best practice was growing, but a full analysis was still to be developed.

Focus of the project

The NHC's investigation focused on:

- primary health care for prisoners
- continuity of care that encompasses prisoners' entry to, transfer between, and exit from prison
- the health of the families and whānau (especially children) of prisoners
- the relationship between the disproportionate Māori and Pacific incarceration rates and poor health
- questions of ethics, governance, and best practice related to prisoner health services
- strategic considerations for minimising harm, improving health, and meeting the health needs of prisoners and their families and whānau.

Scope of the project

The NHC project focused on the health of prisoners in the prison setting, but also considered the relationship between prisoners' health and health in the community. The project focused on primary health care to prisoners rather than care in hospitals or with external specialists, which may be an area for subsequent investigation.

To preserve participant anonymity, the names appearing after quotations are not participants' real names.

This report does not address the health issues of people in the wider criminal justice system – people in police cells, in courts, on parole, and on probation, people who spend time only in secure intellectual disability or forensic units, and people who serve only community sentences. The NHC recognises the impact of the prison setting on the health of prison staff, but this issue is also beyond the scope of this report.

To keep the project manageable, the NHC decided not to include people in the youth justice system, but it did include people aged under 17 who are detained in adult prisons.[20]

The NHC also excluded consideration of the specific health needs of women and babies in prison, because legislation on this topic was being considered when the NHC began its project.

Sources of information

The NHC gathered its information from:

- an international literature review on the health effects of imprisonment on prisoners and their families[21]
- reviews of prisoner health or matters relating to health in New Zealand prisons
- reviews and analyses of the literature on other related topics
- age-standardised comparisons of health indicators between the prison population and the general population (see Appendix II)
- the 'What would a health-promoting prison system look like?' workshop in September 2007 that was attended by 85 health professionals, officials from the Ministry of Health and Department of Corrections, prison employees, former prisoners, and prisoner advocates[22]
- submissions from prisoners, their family and whānau, and advocates
- interviews with experts in health and criminal justice in New Zealand and other countries and meetings with health providers, officials, and community organisations
- visits to eight facilities in the prison system:
  - Arohata Women's Prison
  - Auckland Central Remand Prison
  - Christchurch Men's Youth Unit
  - Christchurch Women's Prison
  - Mount Eden Prison
  - Rimutaka Prison's Faith-Based Unit and Kaupapa Māori Unit
  - Rolleston Kia Mārama Unit (therapeutic community for sex offenders)
  - Spring Hill Prison
- visits to four secure facilities outside the prison system:
  - Haumietiketike (secure intellectual disability facility)
  - Porirua police cells
  - The Mason Clinic (secure forensic facility)
  - Timata Hou (community-based secure intellectual disability facility)
- primary research on the health of prisoners (Litmus Ltd interviewed 60 men and women in five North Island prisons six weeks pre-release and 26 prisoners and family members four to six weeks post-release)[23]
- primary research on the health effects for families (Wesley Community Action held 46 interviews with members of 25 families or whānau who have a member in prison; respondents were from five areas)[24]
- attendance at conferences related to prisoner health and reintegration in New Zealand and Australia.

Part One: Prisoners in New Zealand

2 Introduction to Part One

New Zealand's incarceration rate is very high by international standards, especially for Māori.

Prisoners, on average, have less education, come from deprived communities, are mostly men, and have significantly poorer health than the rest of the population.

Part One describes the prisoner population in New Zealand (section 3) and this population's poor state of health and wellbeing (section 4). It then explains why prisoners have poorer health than the rest of the population (section 5).

3 New Zealand's prisoner population

This section overviews the New Zealand prison population in terms of incarceration rates and demographic characteristics.

3.1 Imprisonment rates

In May 2010, 199 out of every 100,000 people in New Zealand were in prison.[25] This is the sixth highest rate of imprisonment in the OECD and the 60th highest rate in the world.[26] However, the rate for Māori is about 700 per 100,000 people.[27]

In general, Māori are more likely to be imprisoned than non-Māori but disparities are even greater in some age groups. For example, in 2009, 3 percent of 25-year-old Māori men were in prison; over seven times the rate of 25-year-old Pākehā men.[28] In the same year, 19- and 28-year-old Māori men had imprisonment rates almost 10 times the rates of Pākehā men of the same age.

In 2009, Pacific offenders made up 11 percent of the prison population, almost double their representation in the New Zealand population. A larger proportion of Pacific prisoners were sentenced for violent offences (48 percent) than Māori prisoners (38 percent) and New Zealand European prisoners (25 percent), but Pacific offenders have a lower average risk of reconviction than Māori or New Zealand European offenders.[29]

The number in prison fluctuates daily, but on 30 June 2009, 8,487 people[30] were in prisons (ie, the prison muster)[31] managed by the Prison Service.[32] The average annual cost is about $91,000 per person.[33]

Most prisoners are detained only briefly before returning to the community. About 80 percent of all prison sentences are less than six months[34] and less than 5 percent of those released each year have spent more than three years in prison.[35] Around 20,000 people[36] per year spend time in prison. Fifty-two percent of prisoners will be back in prison within five years.[37] This rate increases to 58 percent if the prisoner is Māori[38] and 71 percent if the prisoner is aged under 20.[39]

3.2 Demographic characteristics of prisoners

Compared to the general population, the prisoner population, on average, has a lower level of educational attainment and higher levels of socioeconomic deprivation and unemployment and is 90 percent male.[40]

The prison population is younger than the general population. Offending behaviour tends to peak in the late teens and early 20s, and most people are aged 19–22 when they are first sentenced to prison.[41] However, lengthening sentences, longer periods of offending,[42] and the cumulative effect and increasing use of indeterminate sentences[43] are contributing to the ageing of the prison population. Although the prison population is younger than the general population, prisoners aged 50 and over are making up a small but rapidly increasing proportion of the total prison population. The group aged 50 and over grew from 4.5 percent of the prison population in 1991 to 9.1 percent in 2009.[44]

Pacific prisoners also tend to be younger, less educated, have a lower health status than the general population, and come from a low socioeconomic background.[45]

The prison population also contains an increasing number of women.[46] As at June 30 2009, there were 389 women in New Zealand prisons.[47]

People who are imprisoned come from a variety of family and community settings, including:

- living with a partner and children, often in reconstituted families – about 87 percent of female prisoners and 65 percent of male prisoners have children[48]
- having children but not living with them (and with whom they may or may not have regular contact)
- being an older person and living with a partner or alone
- for Māori prisoners, having strong links with hapū and iwi or having limited or no understanding of whakapapa and no links with te ao Māori
- living in 'closed communities' such as gangs
- being a primary carer of a family member such as a parent, grandparent, or child requiring substantial support
- living alone and alienated from family because of the crime they have committed, relationship breakdowns or family dysfunction.

The families of prisoners tend to be among the poorest in society. They are often in crisis before the arrest occurs and are often under significant financial and relationship stress.

4 Health and wellbeing of prisoners

4.1 New Zealand prisoners have poor health

There is little good quality empirical evidence on the health status of New Zealand prisoners. Available evidence is broadly consistent with research in other developed countries.

In New Zealand and internationally, prisoners typically score poorly on measures of mental health, alcohol and other drug use, chronic disease, communicable disease, disability, head injury, health risk and protective factors, and oral health. Appendix II presents key figures on the health of New Zealand prisoners. International research on the health of prisoners in developed countries is summarised in Appendix I.

Clear gaps exist in the published New Zealand data and analysis. Few comparative studies show the relative health status of New Zealand prisoners compared with the broader population. There is no routine surveillance of prisoner health, and the main source of survey data relies on self-reporting, so is likely to underestimate disease prevalence. There is little data on the health status of specific groups within prisons, such as Pacific people.

To begin to address this concern, the NHC commissioned or developed the comparative figures shown in Appendix II. The NHC obtained data about the prevalence of certain health conditions from a number of sources; see Appendix II. Some surveys relied on self-reported responses. There are likely to be a number of limitations in comparing the prevalence of conditions reported in the prison population to those reported in the general population. It is also important to note that many of these analyses did not reach statistical significance, and are based on small numbers.[49]

Regardless of the limitations and data gaps, the message is clear – New Zealand prisoners have very poor health.

Appendix II shows the prevalence of serious mental health conditions such as major depression, post-traumatic stress disorder, obsessive–compulsive disorder, and schizophrenia appear to be higher in the prison population than in the wider population.

The lifetime prevalence of alcohol abuse and dependence among men in prison is approximately twice that of men in the wider population. The lifetime prevalence of severe drug disorder is eight times that of the wider population.[50] Research has found that 89 percent of prisoners have suffered a substance abuse disorder at some time in their lives, primarily alcohol and cannabis abuse and dependence. The same research found that nearly 60 percent of prisoners had a personality disorder.[51]

The lifetime prevalence of head injury among prisoners is high. Among women, the rate is 55 percent; among men, the rate is 64 percent. Almost seventy-four percent of Māori men in prison have had at least one head injury.

Smoking rates, after adjusting for age and ethnicity, are also strikingly elevated among prisoners compared with the wider community – nearly three times the rate for men and more than four times the rate for women.

The chronic disease figures are mostly consistent with the high smoking rates. After adjusting for age and ethnicity, men have 3.3 times the rate of heart disease in prison and, for those over 45, more than twice the rate of chronic obstructive pulmonary disease than men in the wider community.

The cancer statistics are an outlier, showing men in prison have a lower prevalence of cancer than the general population.

Women in prison have about twice the rate of asthma compared with women in the wider community.

After controlling for age and ethnicity, men in prison are more likely to eat two or more pieces of fruit a day and have a marginally lower prevalence of being overweight or obese than men in the wider community.[52]

Communicable disease rates are elevated among the prison population. The general population prevalence for hepatitis C is less than 0.3 percent compared with the prisoner prevalence of 8.1 percent for women and 5.8 percent for men.[53]

4.2 Extent of co-morbidity in the prison population

We know something about the prevalence of the individual particular health conditions in prison, but we know little about the co-existence, or co-morbidity, of health conditions in the prison population. Eighty three percent of prisoners identified as having a psychiatric disorder in *The National Study of Psychiatric Morbidity in New Zealand Prisons* also suffered from substance abuse or dependence.[54] Other co-morbid relations are suggested by international studies. For example, Australian research estimates that up to 30 percent of institutionalised offenders with intellectual disabilities and half of those in community habilitation projects are affected by a psychiatric disorder.[55] The full burden of disease and risk factors in the prison setting cannot be known without taking account of co-morbidity.

4.3 Extent to which prisons capture a 'special case of health need'

Better information is needed about the extent to which New Zealand prisons capture a 'special case of health need' rather than just reflecting what would be expected given the known demographics (age, gender, and ethnicity) of the prison population.

The results in Appendix II show that, after adjusting for age and ethnicity, high prevalence persists for smoking (men and women), heart disease (men), chronic obstructive pulmonary

disease (men), asthma (women), and schizophrenia (men). For these conditions, it appears a special case of health need exists in prison. Further research may reveal the same for other health conditions.

International research is more rigorous when controlling for known confounding factors on health status. For example, a recent study in the United States of 20,955 prisoners and 76,597 non-institutionalised adults controlled for sex, age, race, education, employment status, the US as birth place, marital status, and alcohol consumption.[56] The study found inmates had significantly higher likelihoods of hypertension, asthma, arthritis, cervical cancer,[57] and hepatitis than non-institutionalised adults. In line with the comparative findings from New Zealand (Appendix II), the authors concluded that their research 'contradict[ed] the common perception that poor health among inmates is driven solely by high concentrations of racial/ethnic minority men in correctional systems'.[58] This strongly suggests negative influences on health arise from the prison environment.

5 Why prisoners have poorer health than the wider community

The genesis of poor prisoner health is complex and related to both community and prison settings. Although New Zealand lacks the data to draw definite causal pathways, the evidence suggests the community setting is a powerful influence on the development of the health of prisoners – particularly during critical periods of physical and neurological development in early childhood, adolescence, and young adulthood. The evidence also suggests that imprisonment can contribute significantly to poor health outcomes – particularly for the young or otherwise vulnerable. The longer an individual is in prison, the greater this contribution will be.

5.1 Prisoner health reflects community health

An individual's health is the result of genetic, biological, behavioural, social, and economic influences that change with age and experiences.[59] Health status can be influenced through genes, infection, injury, or health care, but health and wellbeing are largely shaped by an individual's situation within the wider community context.

As in other countries, New Zealand's prisoners tend to come from groups that already face the greatest health inequalities. A disproportionate number of prisoners are young people, Māori, Pacific people, people with limited financial security, and people with low education and employment levels.

Before arriving in prison, many people have had unhealthy lifestyles and lived in physical environments that are hazardous to their health (eg, substandard or overcrowded accommodation). A disproportionate number is likely to be homeless.[60]

Prisoners also tend to come from a socioeconomic context in which risks to their health, including being victims of crime themselves, are high and opportunities to improve their health are limited. Unsurprisingly, health needs tend to be greater in those neighbourhoods and communities with members who are more frequently imprisoned.

Poor health has a relationship with other social ills, so we can expect those communities making the most significant contribution to the prisoner population to be of interest not just to the health sector, but also to agencies such as Child, Youth and Family, the Ministries of Education and Social Development, and the New Zealand Police.

5.2 Poor community health is associated with criminal behaviour and imprisonment

New Zealand longitudinal studies have produced world-leading research on health and human development.[61] These studies show that if healthy developmental processes are damaged or interrupted, a person's potential can be compromised. This disruption to healthy development makes people more likely to follow a life-path that includes lifelong poor health, poverty, poor educational achievement, unemployment, family and other violence, crime, and imprisonment.[62] The New Zealand studies show that early in life the effects of exposure to health risks are magnified.

The NHC commends the Government's early childhood workstream, as part of the Drivers of Crime initiative, and the evidence-based approach it has taken in making early intervention a priority. However, New Zealand needs to make additional efforts if our children are to reach their full potential rather than spend any of their lives in prison.

Although the prenatal and early infancy period is the most critical in development, it is not the only one. Evidence suggests that if neurobiological processes are disrupted, subsequent stages of development, including adolescence and the finalisation of frontal lobe formation in young adulthood, may also be affected. Many offending behaviours[63] naturally peak with these periods of development.[64] Those whose health has been impaired show heightened criminal tendencies, begin such behaviour earlier, and are less likely to 'age out of crime'. They are also more likely to be a negative influence on their peer group.

Poor health and related social outcomes can be repeated across generations. Research from the Dunedin Multidisciplinary Health and Development study demonstrates that although poor child health and behavioural problems indicate an increased risk of involvement in the justice system, the causal links are complex and trajectories change. All child health interventions should be concerned primarily with improved health outcomes. This means addressing the determinants of health as a first principle.

The evidence from the Dunedin Health and Development Study shows that those with the greatest problems across health, criminal, economic, and social domains are more likely than their peers to be parents with half of the men and 75 percent of the women in this group having children by age 32.[65] Children's health is at risk as long as their parents remain unhealthy and impoverished. Imprisonment is an opportunity to intervene and improve health outcomes for both prisoners and their families and whānau.

5.3 Prison environment negatively affects health

Regardless of background, an individual arriving in prison enters a setting that is globally recognised as unhealthy and non-therapeutic.

Internationally, common catalysts for poor health within prisons include 'crowding, exposure to violence, illicit drugs, lack of purposeful activity, separation from family networks and emotional deprivation'.[66] Other major contributors to poor health are a culture of intimidation and exploitation, an institutional environment in which health needs are not prioritised, and, particularly for remand prisoners,[67] the uncertainty and stress inherent in being in the criminal justice system. This is the same in New Zealand, although the Prisoners Health Survey 2005 also recorded a few positive signs.[68]

The aspects of the prison environment that worsen health outcomes are the:

- **physical environment**, including poor building design, overcrowding, and substandard living conditions
- **social environment**, in which assaults, sexual abuse, illicit drugs, and lack of purposeful activity are commonplace
- **institutional environment**, including prison practices such as strip-searches, frequent transfers, separation from family networks, and inappropriate use of at-risk units.

5.3.1 Physical environment

Some of the most fundamental human health needs relate directly to the physical environment, including access to facilities for good hygiene practices, fresh air, warmth, sunshine, and exercise. New Zealand's newer prisons are better designed to encourage health and wellbeing, but such features are often lacking or limited in older prisons.

> If you're in seg[regation] you can't go out to rec[reation] at the same time as mainstream so if there's any problems you just miss out. Sometimes you get left in your cell for days at a time with no access to outside ... I was in there for about a week and I was sick of being stuck inside all day so I said to the guard 'come on man, it's a beautiful day outside ... I've been stuck in here for ages and I'm getting depressed. I need some sunshine ... some vitamin D'. And the guard just straight up said 'don't be stupid man, you can't get vitamins from the sun'.
>
> Robert, Pākehā man, 20–30 years (interview)

Poor building design and maintenance

Common prisoner complaints include lengthy periods in cramped conditions, extremes of temperature, inadequate light, unrelenting noise, limited access to fresh air and sunshine, and poor building maintenance. Several people the NHC spoke with linked these issues to personal experiences of musculo-skeletal problems, sickness, mental illness, respiratory conditions, hearing loss, injury, and disability. The NHC repeatedly heard from prisoners suffering from back pain and injury they related to spending most of their time sitting or lying on a thin foam mattress.

Prison environments can also be disabling with many stairs and hard surfaces that limit mobility and increase the risk of injury, especially for prisoners whose ease of movement is already impaired. The NHC met several people whose prison sentence contributed to a lifelong disability.

The design and location of many prisons make them prone to extremes in temperature, with older prisons reported as being more cold and damp than newer prisons. Prisoners and their families and whānau expressed concern about the effects of constant cold on prisoners' health, particularly increased respiratory problems. The NHC and the Ombudsman observed that cold temperatures are exacerbated by insufficient clothing and a lack of blankets.[69] Resistance to illness is compromised by constant cold.

Extreme heat is a problem in some prisons. The Ombudsman has criticised the Department of Corrections for not providing fans to prisoners who could not afford them, yet were confined to unacceptably hot cells.[70] A healthy indoor environment is 18–22 degrees celsius,[71] is clear of mould, pollutants, and infections, and has adequate ventilation.

Although the NHC is impressed with the efforts of the Department of Corrections to improve the physical environments in newer prisons, some prison buildings still let in little sunlight or fresh air.

Crowding

The NHC is concerned that the efforts of the Department of Corrections to provide a sanitary and humane custodial environment are being undermined by the continuing growth of the prison population.

Prison crowding is internationally recognised as hazardous to the health of inmates. A crowded prison is more prone to the spread of communicable disease and deterioration in the mental health and safety of its occupants. Crowding puts pressure on both staff and prisoners, increasing risks to safety and decreasing the likelihood of adherence to procedure. For example, when prison numbers exceed capacity, people spend much longer in particular places of confinement than those places were designed for.[72]

Crowding, small living spaces, and double-bunking can have a detrimental effect on mental health:[73]

> Double-bunking basically means you don't get any privacy at all. To me that's a real issue. A real health issue. A mental health issue as well. No moment's peace. Gets you irritated ... As soon as they shut the door [the cellmates] start beating up on each other. ...I've known those situations where they fought for an hour and a half before the guards finally went down and dealt with it. High stress – all of the effects of high stress. Over-production of adrenaline.
>
> Scott, Pākehā man 30–40 years

Internationally, high rates of infectious diseases in prisons are common due to the prison environment and the effects of assaults, drug injecting, tattooing, and unprotected sex. Crowding increases the rates further. In spite of their seriousness, many blood-borne diseases such as hepatitis can go undetected for long periods.

Substandard living conditions

Low standards of hygiene are not only risks for contagion, but have a social impact:[74]

> Substandard environmental conditions further contribute to feelings of being second-rate, undeserving and unclean. This include[s] having to defecate in a bucket [in one's cell where one also eats and sleeps], blood from violent incidents being left on floors for prolonged periods, [and] the presence of flies, cockroaches, rats and pigeons.

In the Prisoner Health Survey 2005, almost one in three New Zealand prisoners reported having had a communicable disease or parasite; most frequently chlamydia (among women), scabies, and lice.[75] The survey did not enable prisoners to specify when or where they experienced the disease or parasite. Prisoners the NHC talked to linked some of their experiences of infection to poor hygiene and the state of prison bedding.

The NHC has determined, through talking with many prisoners, former prisoners, and service providers, that hygiene standards in at least some prisons can and should be improved. Prisoners reported institutions not being cleaned of dirt and blood. They were disheartened at how difficult it was to obtain dental floss or mouthwash and, in spite of their best efforts, were distressed at the state of their personal hygiene.

Nutrition and exercise

The Department of Corrections attempts to maintain reasonable nutritional standards. However, prisoners and their family and whānau are concerned that prisoners' nutritional needs are not being met, particularly for young prisoners, male prisoners, and prisoners with a fast metabolism. The NHC was also told of prisoners being forced or persuaded to give their food to others. Although the Prisoner Health Survey 2005 showed respondents tended to eat the recommended servings of fruit, prisoners commonly complained of insufficient access to fresh, nutritious food.[76]

The Prisoner Health Survey found that 25 percent of prisoners had become more physically active and 44 percent of prisoners had become less physically active since entering prison. The NHC heard from several prisoners (especially women) that, although they were eager to use their time in prison to get fit and healthy, their opportunities for doing so were severely limited.

The Office of the Ombudsmen has reported differences in access to exercise and recreational opportunities between prisons.[77] Balls are not always available, and some exercise yards for medium and maximum security prisoners are small concreted spaces. The office was critical of prisons that failed to provide adequate space and equipment for meaningful sport or recreation. The office recommended a review of recreational opportunities with a view to extending them.

The NHC supports a review of recreational opportunities with a view to extending them. Exercise is essential to maintain physical health and mental wellbeing.

5.3.2 Social environment

Prison is a distressing social environment unlike any most New Zealanders experience – a culture shaped by intimidation, assault, and sexual violence. People often adapt in ways more harmful than helpful. This culture differs from prison to prison, but its negative effects can be mitigated by alternative environments (eg, faith-based, Māori focus, and Pacific focus units).

Frequent assault and injury

Assault is common in prisons. In 2008/09, 515 assaults were recorded in New Zealand's prisons; 43 as serious.[78] Every respondent in the NHC-commissioned research had been involved in violence in prison. These respondents reported the loss of teeth, broken noses, perforated eardrums, and broken limbs.[79] The NHC heard that prisoners sometimes stop taking prescribed mental health medication, so they can stay alert to protect themselves.[80] Many respondents and some prison officers believe double-bunking will result in higher rates of violence:[81]

> There is always a lot of violence when two people are in one cell, always, and it goes unreported. I know of people being raped. I know of a man being murdered.
>
> Meki, Pacific man, 30–40 years

Rape, sexual abuse, and harassment

International experience and local accounts suggest rape, sexual abuse, and harassment are problems in New Zealand prisons:

> He was made to do everything and anything ... He told me he was raped and beaten and made to have oral sex and stuff like that ... [then when he came out]. He just couldn't deal with anything normal any more, he was just a mess ... If something like that happens – you have to have counselling – you have to have someone there for you – you just can't expect to be raped and beaten and then carry on with your life like nothing has happened. It just doesn't work that way. – Sisters of a young prisoner who killed himself while incarcerated.[82]
>
> I know the harassment they get, sexually abused, degraded – they take their souls – that's why some commit suicide.
>
> Grandparent of prisoner[83]

Two female research participants discussed having sexual relationships with prison officers. Each relationship lasted for less than three months and ended abruptly when the officers became concerned that the relationship would be discovered. Neither inmate told anyone about the relationship:[84]

> I suffered in silence. I just cried myself to sleep. At one point I couldn't see a way out and all I wanted to do was die. It's been two years now. It's really hard when I see him ... you know he treats me like I don't exist. I feel really led on ... you know abused. It shouldn't be allowed. I know now that it is an abuse of power.
>
> Miri, Pacific woman, 18–25 years

The prisoner's story quoted above highlights the potential for heightened distress when instances of sexual violence, harassment, or exploitation occur in a closed setting:[85]

> victims may regularly encounter the setting where the abuse occurred – in some cases their own cell. It may also be impossible to avoid their abuser, causing them to continually relive the incident and maintaining the trauma.

Although physical injury, disease, and pregnancy are some of the potential consequences of this sort of abuse, the most significant outcome in many cases is lasting emotional damage. The United States National Prison Rape Elimination Commission found that even outside prisons between a third and a half of rape victims consider suicide and around 18 percent attempt it.[86]

Adaptations to prison culture are more harmful than helpful

Internationally, prison culture is recognised as encouraging prisoners to adapt in ways that are more harmful than helpful (ie, maladaptations) such as hyper-vigilance, paranoia, and aggression.

Aggressive and avoidance strategies can have deep, and sometimes permanent, psychological, emotional, and behavioural ramifications; none of which translates well into families or the wider community.[87]

> In prison, people are always testing your boundaries and whether you are tough enough to [stand up for yourself].] It happens as soon as you arrive ... like someone will shoulder barge you in front of everyone to see how you're going to react.
>
> Interviewer: So how would you respond to something like that – a shoulder barge in front of everyone?
>
> You have to put everything you've got into it ... just jump on the guy and go nuts – even if he's way bigger than you and you know you're gonna get a hiding. Straight away you gotta let everyone know that there's a cost to them if they [mess] with you ... that if they disrespect you or take your [belongings] there will be trouble for them ... you gotta make them think it's not worth it. If you can't do that then you're [in trouble] – everyone's gonna see you as [an easy target] and your lag is gonna be hell.
>
> Robert, Pākehā man, 20–30 years (interview)

> My cousin was a completely different person when he came out of prison. He went in this sweet hearted kid and came out this angry, violent person. He was like a stranger to us. It was like something inside him had died.
>
> Justin, Māori man, 30–40 years (interview)

The NHC investigation highlighted that negative aspects of prison life such as gang culture, standover tactics (blackmail for 'rent'), and the threat of violence led to 'heightened states of anxiety over prolonged periods, assault ... the loss of property ... and [prisoners' families] being extorted to provide funds to protect the individual'.[88] The researchers observed that prisoners with mental health conditions were among the most vulnerable.

In prison populations, stress is significant, continuous, and likely to lead to higher rates of chronic disease and mortality. This underscores the need for models of care that emphasise prevention and early intervention, including mental health and cardiovascular risk assessments and responses.

Lack of stimulation

Long periods of isolation can lead to anger, frustration, and anxiety.[89] Respondents to the NHC research cited inactivity as an antecedent to 'violence, drug use, gambling and general "mischief"'.[90] Prisoners also described how a lack of meaningful activity weakened their mental health and encouraged drug taking, bad behaviour, and aggression.

A Prisoner Aid and Rehabilitation Society worker reported that prisoners who cannot read because of poor eyesight and bad lighting are subjected to long periods with no mental stimulation because there is little else to do during long lock-downs.

5.3.3 Institutional environment

Prisons exist through a societal consensus that detention is the best response to more serious breeches of the law. In casting light on the cultures and institutional environments of prisons, The NHC's intention is not to call into question their existence, but to highlight the physical and social conditions that can erode the health and wellbeing of those detained.

Prison culture undermines respect and mana

People in prison are separated from their normal lives and must take on the role of 'prisoner':[91]

> offenders sent to prison enter a complex social world of values, rules and rituals designed to observe, control, disempower and render them subservient to the system.

Strip-searches and invasions of privacy and intimacy remain a largely unquestioned reality of the prison experience.[92] The Australian organisation Sisters Inside asserts that these 'correctional' invasions do more than just remind prisoners of previous abuse, they are institutionalised forms of physical, psychological, and sexual abuse perpetrated by the state and accepted by society.[93] These practices are culturally inappropriate for many women, and could have a particularly damaging effect on those whose self-respect is linked to notions of modesty or whose histories have taught them to be ashamed or scared of exposing their body. Prisoners find these activities degrading:[94]

> Lift your breasts, spread your legs, lift your hair, open your mouth, lift your tongue ... I hate it, it's humiliating.

New Zealand's prisoners share the sense that they are treated in disrespectful ways, often leading to lower self-esteem, poor wellbeing, and an erosion of mana. For instance, respondents identified the dehumanising implications of terms such as 'muster', of strip-searches, and of being 'herded' into holding cells:

> Prisoners commonly referred to being treated worse than an animal because they are required to eat, sleep and defecate in the same area.[95]

> Keeping it cool inside is what matters in here, people are just as shattered as I am. I don't blame them. We're only human, that's what counts. The system thinks we're all machines that switch off and on when they please. Locked-down caged animals it's the label they put on us.
>
> Hohepa, Māori man, 20–30 years (in a letter)

> We have to bend down, knickers to the knees, bend down in front of them and show them, you know. It's humiliating you know I think that's wrong. I think that's very wrong and I think that's a broken code of privacy and tikanga. ... I think the officers they actually need to learn a lot more about the tikanga because like here it's a Pākehā system they don't seem to give a damn about the Māori side of things.
>
> Tui, Māori woman, 30–40 years[96]

> The way they talk to you and look down at you, they really do let you know that you are just an inmate ... it's quite degrading really.
>
> Annette, Māori woman, 30–40 years[97]

Breaches of tikanga and erosion of mana undermine the hauora (health) of both Māori and non-Māori prisoners and have implications for whānau ora – particularly on release. New Zealand's prisons need to be culturally safe by recognising in policies and practices the norms and values of all prisoners.

At the NHC workshop, the belief was expressed that shame is instilled and respect is removed in prison. Mana needs to be protected or restored. A sentence to imprisonment should not undermine someone's dignity or their ability to appreciate and achieve their full potential; nor should it undermine their ability to contribute to the health of their family or culture. The principles of whānau ora, including ngā kaupapa tuku iho,[98] must be better integrated into all of New Zealand's institutions.

Prisoners often have low expectations of health care, so do not seek or receive it. Onerous and seemingly pointless institutional procedures further underscore for prisoners their subordinate role in a way that can be destructive of self-esteem and trust of the officials of the institution. For instance, the NHC heard two stories in which a prisoner who needed an extra pillow for health reasons was initially denied one. One prisoner had to fill out forms and go to three people;[99] the other found the nurse could not get a pillow from the officers and thought better of pursuing the matter, saying she had to 'pick her battles'.

Prison culture discourages help-seeking behaviour

The prison environment discourages displays of vulnerability and help-seeking behaviour by prisoners.[100] If a prisoner expresses emotion or raises a complaint in a prison setting, they may be penalised with lost visiting privileges or work opportunities or a negative report to the Parole Board.

At the NHC workshop, the NHC was told about a 19-year-old woman who was 'troubled' and progressively deprived of the things she valued as part of the prison's behaviour management procedures. Her experience of prison staff was variable (some were nice, some were vindictive). She eventually killed herself while in isolation.

If a prisoner displays emotion, they may be placed in an at-risk unit.[101] Prisoners regard these units as a second form of punishment.[102]

> I had a bit of a tear because I was thinking about my kids; just a little bit of a tear in the eye. Then they go, 'how about we just put you on observations for the night?' ... One night turned into like three weeks and I told them every day, 'Mister can I go back to remand? I am real good'. ... three weeks later I was still [in] At Risk. Like straight up I was going nuts.
>
> Anaru, Māori man, 18–25 years

At-risk units used inappropriately

At-risk units are prison wings where prisoners can be kept in isolation cells and under continuous observation to minimise the risk of the prisoner self-harming or harming others.

At-risk units are designed for stays of up to a week, yet the NHC heard of people being kept in them for months at a time.[103] One woman remained in a unit for 18 months with only a 'couple' of days back in the mainstream prison population.[104]

At-risk units are small, bare cells to which the prisoner is sent without shoes or other items, dressed in a stitched rectangle of fabric designed to minimise the risk of suicide. Some units have a fixed concrete bed and toilet; others have only a mattress on the floor and a plastic container for toileting. At night, light and noise can be constant. If facilities exist and staffing levels allow, prisoners may 'lounge' for part of the day in larger, bare rooms, but they must do so alone but under constant surveillance. Prisoners in at-risk units have no access to the outside world, no fresh air, and almost no human contact.

Prisoners perceived at-risk units as punishment:[105]

> I needed time out. Somewhere quiet, peaceful and safe. But there's only [the at-risk unit] ... an empty room with no stimulus. It makes you go crazy. It's a punishment. You lose all privileges. After your first time you do everything you can to avoid it in the future.
>
> Siaki, Pacific man, 20–30 years

The inappropriate use of at-risk units for behaviour management, detoxification, 'time out' or punishment, and the segregation of vulnerable prisoners is driven by a lack of alternatives in full prisons and exacerbated by the prevalence of untreated mental illness, including personality disorder, among the prisoner community.[106]

However, a custodial environment need not be so negative. Contrast the environment described above with the atmosphere in a specialist Māori focus, Pacific focus, or faith-based unit:[107]

> It's an environment that's different from any other place in prison or in rehab. It's just an environment where people genuinely care for you. Like they call you by your first name. You get into a position where you really start to care for people. Like if you're a new guy the first thing that happens is pretty much most of the unit comes over and welcomes you here and things like that which you don't get anywhere else in prison.
>
> Jonathan, Pākehā man, 18–25 years

These specialist units focus on prisoners' personal wellbeing and developing self-esteem, a sense of identity and competence in the world, a sense of having a role in the family and community, and compassion.

Frequent inter-prison transfers

Inter-prison transfers are commonplace. Transfers are undertaken for a variety of operational reasons, but prisoners commonly regard them as a 'form of punishment'.[108] Supportive social networks developed in prison as well as family connections can be destroyed by transfers between prisons. Therapeutic relationships such as with the local forensic team are likely to be disrupted.[109]

5.4 Health, reintegration, and reoffending

Prisoner health needs are often heightened during the period of their reintegration into the community, when progress in treatment is likely to be halted or delayed. Reintegration is a stressful time for many people, particularly those who have completed long sentences. The longer a person has been in prison, the fewer resources they have to live a healthy life in a community setting. Few people leave prison with money,[110] there is often no official transfer of their health records, the medications they need may be unattainable, and people often lack stable or suitable accommodation.

A prison sentence results in lost jobs, rent and mortgages not being paid, and the erosion or end of relationships. Although some former prisoners are supported by family and whānau, friends, or community organisations, many are released into a community they do not know or in which they are no longer welcome. Some people will sever connections on purpose. Many prisoners plan to stay in the area of their prison on their release.[111]

The NHC talked to several people who, when released, had no one waiting at the gate and no idea where they were going to stay the night. This group included a 17-year-old who had no idea where his family had gone while he was in prison. He thought they might have moved to Australia.

The partner of a prisoner told the NHC:[112]

> The biggest challenge for us is not having enough support for him, he's been in jail for 10 years, so basically the whole world has changed, there was no integration, no home leaves ... Maybe the prison should have provided more family time to have spent with him to bring him up to speed with what's going on out here, I reckon that would have made a hell of a difference, a huge challenge for him [when he got out].

If health issues have developed or worsened during a prison sentence, they are likely to complicate what is an already difficult and often under-supported transition.

5.4.1 Post-release mortality

Not everyone survives the period of reintegration. The risk of death in some groups spikes immediately after release. New Zealand lacks data on the mortality rates of its former prisoners, but similar jurisdictions have found a far higher rate of mortality among former prisoners, particularly in the first two weeks of release and particularly through alcohol and other drug overuse.[113] A longitudinal Australian study noted that 'for all causes of death, except cancer in women, the mortality rate was significantly higher in the prisoner cohort in comparison with the NSW population'.[114] The study also found 'the excess all-cause mortality increased with increasing number of imprisonments'.[115]

Initiatives in overseas jurisdictions to prevent post-release mortality include transition support, aftercare, and overdose kits for injecting drug users.

Prisoners are at risk of greater social exclusion on release,[116] particularly if they have served a long sentence. Therefore, it is interesting that a longitudinal study in the United States concluded that 'men with a low level of social support were two to three times more likely to die over the next dozen years than men with a high level of social support'.[117] One prisoner the NHC spoke with said:

> You need your friends and family and those relationships built back up ... there wasn't enough within me or within my life at that point to make me want to change ... That's what my family gave me. They reminded me of what I had to lose and helped me to see when I was making progress.
>
> Michael, Pākehā man, 18–25 years (interview)

5.4.2 Access to health services and continuity of care

A prisoner's health needs are heightened during their release period, but they often have difficulty accessing health services in the community, and current health services do not sufficiently prioritise continuity of care.

Prisoners move from an institutional context in which everything was done and provided for them to an individual and community context where everything is their responsibility. The structure of the prison routine could help to embed healthy behaviours. However, even when investments in health are made during the sentence, many prisoners leave prison without a plan or the resources to protect and improve their health in a community setting. Without such support the need for repeated investment – from both Vote: Health and Vote: Justice – is more likely.

The cost of access to health services can be prohibitive, particularly for former prisoners with no or low incomes, who are unable to access sufficiently low-cost health care, or who have to travel significant distances to access such care.

Former prisoners may have been enrolled with a health provider before their sentence, but many need to re-enrol. However, some providers (eg, general practitioners, alcohol and other drug counsellors, and mental health providers) are unwilling to provide health care to former prisoners, and advocates have stressed that discrimination is a barrier to their health care. Furthermore, many providers are not taking new enrolments. The area around Rimutaka Prison in Upper Hutt is a good example. Newly released prisoners have to travel to Wellington to visit the handful of low-cost providers willing to attend to their health needs.

The NHC's research highlighted that many former prisoners do not understand the health system and their entitlements within it. One prisoner explained that he did not think he could afford health care and had no idea that the hospital would provide free treatment, so he put off getting an injury seen to until he was in danger of losing his life.

Conversations with those who spend time in our prisons also highlighted that some place a high value on independence from state intervention. Many of the communities over-represented in prison are also unwilling to engage with services they feel are not ultimately there to help them.

5.4.3 Link between poor health and re-offending

This report has already outlined the association between poor health and crime, so the association between poor health and re-offending is unsurprising. Over half the prison population will return to prison within the next five years; many more than once.

Too many people repeatedly come before the courts and are sent to prison with health needs that remain unaddressed. As long as they remain unaddressed, health issues such as addiction and mental health conditions will continue to drive the same offending behaviours. These factors, combined with a lack of appropriate support and continuity of care on exit from prison, increase the likelihood that people will commit further crimes and be reincarcerated.

Part Two: How the Health Sector Can Lead Change for the Health of Prisoners and their Families

6 Introduction

Part Two highlights the extent to which services are not meeting needs and may actually be exacerbating health problems and increasing inequalities. The NHC recommends that prisoner health care match that of the general population.

Part Two proposes significant changes to principles, planning, and service delivery, the development of stronger relationships within and between the health, justice and other relevant sectors, and consideration of the appropriate structure for prisoner health. These changes are discussed, along with their associated recommendations, in sections 7–10.

6.1 Arrangements for provision of prison health services

6.1.1 Provision of prison primary health care

The Department of Corrections holds statutory responsibility and the funding (through Vote: Corrections) for the delivery of *primary* health care for prisoners.[118] The services that must be provided in each prison are set out in the Prison Health and Disability Support Service Specifications.[119]

These primary health care services are carried out by a workforce of nurses with other health professionals contracted on a sessional basis.

6.1.2 Provision of public, secondary, and tertiary health care

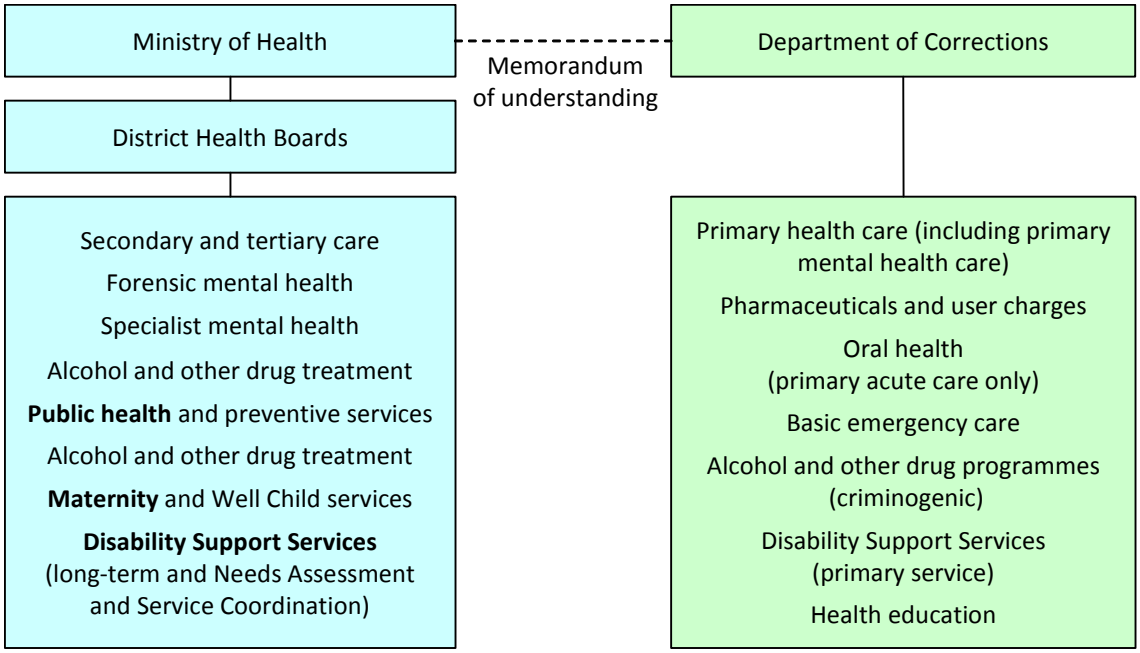
The Ministry of Health funds (through Vote: Health) other health services for prisoners. It funds District Health Boards (DHBs) to provide public health services and all secondary and tertiary care (including alcohol and other drug services and specialist mental health services). The Accident Compensation Corporation also funds some services.

DHBs provide forensic mental health services on a regional basis through the Regional Forensic Psychiatric Service (including Hauora Waikato). Each regional service provides inpatient services in forensic hospitals, a court liaison team, a forensic prison team, and community forensic services.[120]

6.1.3 Relationship between the Department of Corrections and Ministry of Health

The relationship between the Department of Corrections and Ministry of Health is governed by a memorandum of understanding (represented in Figure 6.1). This memorandum has been updated but not reviewed since its inception in 2004.

Figure 6.1: Relationship between the Department of Corrections and Ministry of Health



Note: Items in **bold** are funded directly by the Ministry of Health. Other services funded by the Ministry of Health are the responsibility of District Health Boards.

DHBs' relationships with local prisons are set out in service level agreements.

Non-governmental organisations play important support and liaison roles for newly released prisoners. Offenders in the community – whether serving a community sentence or reporting to Community Probation Services – are eligible for the same health and disability support services as other community members.

6.2 Concerns for prisoner health

Since 2004, at least 15 reports have disclosed serious concerns about the health of prisoners. These reports have come from agencies such as the Controller and Auditor-General,[121] the Office of the Ombudsmen,[122] the Ministry of Health,[123] Te Rōpū Rangahau Hauora a Eru Pōmare,[124] the Human Rights Commission,[125] and the New Zealand Drug Foundation.[126] The Office of the Ombudsmen is also undertaking an own-motion investigation into the delivery of primary health care services within prisons.[127]

The reports expressed concerns about:

- aspects of the prison environment and routine that are detrimental to health
- poor practices in the identification and treatment of health conditions
- disputes over jurisdiction among government agencies, leading to an absence of services.

Most of the concerns these reports raised have remained unresolved. The NHC considers this is because:

- a fundamental conflict exists between the custodial role of the Department of Corrections and the role its health services must play in providing a high-quality service anchored in a philosophy of care
- health is not the core business of the Department of Corrections, so health priorities must compete with other departmental priorities
- responsibility for funding and service provision is divided, unclear, or overlapping between the health and corrections sectors, resulting in patients' needs going unnoticed or unmet between services
- both sectors suffer from a shortage of funding for some health needs
- capacity and capability are lacking in areas of importance to prisoner health (eg, mental health and alcohol and other drug treatment).

6.3 Health sector can lead improvement

Applying health sector expertise and a health perspective to prisoner health in New Zealand would help to address systemic, cultural, and structural problems.

To improve health and rehabilitation outcomes, thus reducing the likelihood of health-related reoffending, the NHC recommends changes to principles, planning, service delivery, and cross-agency relationships, and consideration of the responsibility for prison primary health care. These changes are consistent with best practice in prison health elsewhere in the world.

7 Adhere to principles to guide prisoner health care

The NHC has concluded that a universal and clear set of principles to guide all prisoner health and disability support services needs to be developed and followed. Prisoners are a population with poor health and many are vulnerable in a custodial environment. These principles would put the onus on the agencies providing prisoner health services and disability support to:

- adhere to the principle of equivalence of care based on needs for delivering health and disability support services to ensure prisoners receive the same extent and standard of care in relation to their needs as they would have available in the community
- align health care services in prisons with existing health legislation
- ensure policies and procedures affecting prisoners are driven by the principles of Whānau Ora

- take a prevention and care approach to prisoners' health conditions and disabilities (ie, a therapeutic approach)
- implement health-promoting prison policies and practices
- involve prisoners, and where possible their families and whānau, in designing prison health and disability support services.

7.1 Adhere to principle of 'equivalence of care based on needs'

The principle of equivalence of care in prison medicine is an international standard for prisoner health. This principle is enshrined in New Zealand law and reflects the fact imprisonment is a sentence to a loss of liberty, not a sentence to physical harm or poor health.

7.1.1 Description of equivalence principle

The principle of equivalence of care sets out an expectation that prisoners should receive the same level of health care as they would be entitled to receive if they were not in prison – care that is equivalent in terms of policy, standards, and delivery.[128]

The equivalence principle is in the United Nations Basic Principles for the Treatment of Prisoners (1990):[129]

> Prisoners shall have access to the health services available in the country without discrimination on the ground of their legal situation.

In New Zealand, the equivalence principle appears in the Corrections Act 2004 (section 75):

> (1) A prisoner is entitled to receive medical treatment that is reasonably necessary.
>
> (2) The standard of health care that is available to prisoners must be reasonably equivalent to the standard of health care available to the public.

7.1.2 Delivery of health care does not meet equivalence principle

The NHC has learned from commissioned research and personal accounts that health care in prisons is not always delivered in accordance with the principle of equivalence of care based on needs, and prisoner care does not always meet the needs of the patient.[130] Some services delivered to prisoners from the health sector also fail to meet the equivalence principle.

The Government has a duty of care for prisoners. A sentence of imprisonment takes away a person's liberty, but the person should not lose access to good quality health care. The nature of incarceration means prisoners cannot protect and promote their own health or access health care for themselves, so the Government is obliged to provide it.

7.1.3 Implications of the equivalence principle

The implications of the principle of equivalence of care based on needs are that:

- all services for prisoners should meet the same standards required for health care and disability support outside prison for patients with the same level of need
- all prisoners should be able to access the same level of health care and disability support services as the public outside prison who have the same level of need
- prisoners often have limited financial means and are at increased health risk due to their incarceration, so some services should be provided free to meet the state's duty of care.

7.2 Align health care services in prisons with health legislation

For equivalence of care based on needs to be a reality, the legislation that applies to health and disability services provided to people outside prison should also apply to services provided to prisoners. Two important pieces of legislation are the New Zealand Public Health and Disability Act 2000 and the Code of Health and Disability Services Consumers' Rights.[131]

7.2.1 New Zealand Public Health and Disability Act 2000

The New Zealand Public Health and Disability Act 2000 outlines the objectives for the health and disability sector. These objectives should prevail over the more specific provisions in section 75 of the Corrections Act 2004.

Prison health services should be required to meet the objectives of the New Zealand Public Health and Disability Act 2000, including:[132]

(a) to achieve for New Zealanders –

  (i) the improvement, promotion, and protection of their health:

  (ii) the promotion of the inclusion and participation in society and independence of people with disabilities:

  (iii) the best care or support for those in need of services

(b) to reduce health disparities by improving the health outcomes of Māori and other population groups.

Although these objectives apply for all New Zealanders, including prisoners, it is unclear whether they are required of the corrections health service. This anomaly means the objectives for in-prison primary health care may not be the same as the objectives for secondary health services for prisoners (provided by DHBs).

The New Zealand Public Health and Disability Act 2000 also sets out that:

- every DHB must promote the integration of health services, especially primary and secondary health services[133]
- the health and disability sector must recognise and respect the principles of the Treaty of Waitangi.[134]

The NHC believes both these requirements are important in improving the health of prisoners and their families and whānau, so should be required of primary health care services for prisoners.

7.2.2 Code of Health and Disability Services Consumers' Rights

All New Zealanders, including prisoners, are also entitled to the standard of services outlined in the Code of Health and Disability Services Consumers' Rights.[135]

The 10 rights in the code are the:

- right to be treated with respect
- right to freedom from discrimination, coercion, harassment, and exploitation
- right to dignity and independence
- right to services of an appropriate standard
- right to effective communication
- right to be fully informed
- right to make an informed choice and give informed consent
- right to support
- rights in respect of teaching or research
- right to complain.

The prison setting makes honouring these rights difficult. Research commissioned by the NHC found examples of questionable practice in many of the areas covered by the rights.[136] Some prisoners lodge many complaints, but others are discouraged by the many disincentives created by a custodial environment (see section 5.3.3).

The NHC considers it important that prisoners are aware of their rights and the complaints process in prisons. Health services to prisoners should be monitored with respect to implementing these rights.

7.3 Ensure Whānau Ora principles guide policy and practice

The Taskforce on Whānau-Centred Initiatives has developed a set of Whānau Ora principles that stress the importance of building whānau confidence and skills for achieving whānau aspirations and participating fully in society.

The Whānau Ora principle of 'Competent and Innovative Provision: recognises a need for skilled practitioners to be able to go beyond crisis intervention to build skills and strategies that will contribute to whānau empowerment and positive outcomes'.[137] This principle has particular relevance for prisoners and their families. The opportunity to apply this principle to support prisoners and their whānau has the potential to increase the capacity and resilience of the entire whānau – including the prisoner – and break cycles of criminal behaviour and intergenerational incarceration.

Many prisoners are strongly motivated by their love for, and a sense of responsibility to, their families. Involving family and whānau in a prisoner's therapeutic placement and treatment planning may well improve the prisoner's motivation to, for instance, address addiction. Increasing a prisoner's capacity to protect and promote their own health (eg, through health education or the encouragement of self-care) is likely to have flow-on benefits for whānau.[138] Encouraging family support for a prisoner can also improve relationships and increase family connectedness. This does not just benefit the prisoner but also their children and other family members.

Applying this and other Whānau Ora principles would mean effective resourcing, engaging with whānau, hapū, and iwi, recognising and building on existing capabilities and strengths within the family, and reducing complexity and anxiety by coordinating and integrating services to support whānau aspirations.[139]

Many opportunities exist to involve family members in prisoners' recovery or reintegration in ways that are mutually beneficial. The NHC supports plans announced in Budget 2010, for instance, to build two Whare Oranga Ake units beside prisons in Auckland and Hawke's Bay to focus on the reintegration needs of prisoners, including whānau relationships.

In the current system, many prisoners engage with treatment opportunities only because they are obliged to and see these as something imposed on them. Their lack of motivation can decrease the effectiveness of treatment and undermine the investments being made. The NHC believes that, in many cases, aligning care, sentence, and reintegration planning with the self-expressed needs of the family can only improve this situation.

7.4 Take a care and prevention approach to prisoners' health and disabilities (a therapeutic approach)

A therapeutic approach focuses on the identification and appropriate treatment or support for health conditions and disabilities. This approach requires a focus on ongoing treatment and rehabilitation, rather than on the control and punishment of the individual. The NHC believes decisions about the care and incarceration of offenders must be informed by accurate knowledge of their health and disability status. A therapeutic approach requires appropriate early assessment and quality treatment options and facilities.

7.4.1 Prison is not a good treatment setting for everyone

The NHC believes it is not always appropriate, and is sometimes inhumane, to imprison people with certain health conditions or disabilities. This is particularly the case for prisoners with a significant intellectual or neurological impairment, mental health condition, or personality disorder. For other prisoners, the treatment of a condition such as drug addiction or a chronic condition requires a model of care and treatment that can be difficult to provide in a custodial setting. Many of these individuals are in prison as a direct result of their health problems, but prison is unlikely to be the best place to address those problems. Without assistance, the health of these prisoners is likely to deteriorate, and without treatment or appropriate support

most will commit more crimes. A wealth of evidence exists about better models that can support people to turn their lives around and save public funds.[140]

In the three decades since New Zealand began closing psychiatric hospitals and facilities for people with intellectual disabilities, prisons have become a place of last resort for some people.[141] Innovative and effective responses for people with mental health problems and intellectual disabilities included the development of forensic psychiatric units and intellectual disability secure facilities. However, many people have undetected conditions, fail to meet the legislative or diagnostic criteria for these facilities, or cannot be accommodated in these facilities, so remain in prison.

Among prisoners with addictions, some will have used (and may still use) drugs to cope with past trauma, anxiety, physical pain, or depression. Treating addiction in these cases means addressing the underlying problem such as past abuse, poor oral health or an underlying mental health condition.

7.4.2 'Earliest opportunity' health contact

To achieve the best outcomes for prisoners with severe or complex health conditions or impairments, the NHC suggests that the 'earliest opportunity' principle be applied. This means an offender's health and disability status is assessed at the earliest possible opportunity during their journey through the justice system. This assessment involves appropriate screening and determination of options when people have contact with police or the courts.

For this approach to be successful, suitable identification and treatment pathways must exist, police need timely access to health sector advice, and judges must be aware of the treatment alternatives available and have an appropriate range of sentencing or diversion options at their disposal. Currently, health capacity makes many of these options unrealistic. The health sector needs to be better resourced to respond to the demands of the criminal justice sector and meet criminological as well as clinical health need.

7.4.3 What is needed for a therapeutic approach

How a therapeutic approach is best applied depends on the condition requiring treatment or support and the health and security status of the prisoner.

Because of the risk some offenders pose, they should be treated in secure therapeutic facilities. Some offenders may be able to resume (or begin) a healthy life after prison, if they are correctly identified at the outset of their sentence and treated or taught to manage their disorder within prison. Others will be able to transfer to a non-secure treatment facility.

New Zealand has some excellent therapeutic services for people in contact with the criminal justice system, including:

- the Regional Forensic Psychiatric Service, which operates through DHBs and comprises:
  - the Forensic Court Liaison Service, which is designed to minimise inappropriate convictions and incarceration

  - secure inpatient forensic hospitals and psychiatric services inside prisons
  - transition housing and services
  - liaison with community mental health services[142]
- drug treatment units, which are 24-week therapeutic community residential programmes in prisons. These are the Department of Corrections' most successful programme[143] and three more units are being established
- therapeutic community treatment residences such as Moana House in Christchurch and Odyssey House in Auckland, which draw on best practice principles for recovery and to reduce reoffending.

However, these services are on the periphery of the primarily custodial approach taken to prisoner health in New Zealand. There is unmet need in nearly every aspect of mental health and alcohol and other drug dependence and addiction. Greater investment in mental health services, including alcohol and other drug addiction services and transition supports, is needed to help improve health and reduce reoffending and imprisonment.

Successfully developing and maintaining a therapeutic approach requires adequate health, treatment, and support services. Custodial responses are more likely in the absence of appropriate therapeutic alternatives. Judges are unable to make therapeutic referrals if beds or services are not available and are concerned that this removes treatment as an option at all stages of the court process,[144] making imprisonment more likely. Parole Board officials expressed concern that people are remaining in prison much longer than necessary[145] because no community treatment option can be found. Not only is this inappropriate, but at an annual cost of $91,000 to imprison an individual,[146] New Zealand cannot afford to hold people in prison when there are more effective alternatives.

Recent comprehensive reviews have led the New Zealand Drug Foundation and Law Commission to recommend the use of compulsory drug treatment[147] as an alternative to prison and prison-based treatment followed by treatment in aftercare facilities as necessary strategies to improve health and reduce reoffending.[148]

7.4.4 Addiction – an example of the need for a therapeutic approach

In New Zealand, many people come before the courts and serve sentences without adequate drug assessments or interventions. The Parole Board has admitted it is 'flying blind' with respect to people's alcohol and other drug needs on release.[149] There are also not enough places in residential therapeutic communities and not enough qualified alcohol and other drug treatment providers to treat those who have identified addictions.[150] The capacity of addiction treatment services would need to 'at least double to enable those most severely affected by addiction to gain timely access to treatment'.[151] Instead, some DHBs are cutting community services:[152]

> Even though the Government has identified alcohol as one of its four priorities in its study of crime causes, it has recently allowed district health boards to divert funds traditionally ring-fenced for addiction treatment to meet budget constraints. To not continue to fund,

protect and increase the alcohol and drug treatment sector is short-sighted and based on the outmoded notion that the best way to control alcohol and drug abuse is to punish it.

Treatment for substance abuse and addiction is most effective when it takes place in the community. Community residential drug treatment programmes reduce reoffending by about 30–40 percent (the in-prison drug treatment units' reduction rate is 10–14 percent).

Community-based programmes also provide a greater opportunity for people to continue living with and contributing to their families and whānau. Community residential, particularly community outpatient, programmes increase the potential for parenting, are conducive to ongoing and uninterrupted employment, and are better for embedding positive health behaviours within normal routines and under ordinary conditions. People with substance abuse problems are far more likely to recover and begin a life free of offending, if they transfer directly from prison to a step-down residence or into the care of a treatment provider.[153]

The closer the treatment setting is to a person's family and community setting the more cost-effective it is. Although the in-prison drug treatment units are successful, it takes the resources of at least three separate non-health agencies[154] and at least a year of imprisonment costs before addictions are addressed. Not only are community alternatives less expensive, but they also increase savings in the long term. Evaluations have established that every dollar invested in community residential addiction treatment yields a return of $4–$7, mainly in costs associated with fewer crimes (see the example in Box 7.1). Diversion to community outpatient programmes, on the other hand, yields savings as high as $12 for every dollar invested.[155]

Box 7.1: Using community residential facilities to reduce reoffending, Canada

Canada operates a system of more than 175 community residential facilities on a conditional parole basis (ie, the person must attend or return to prison). Some of these facilities provide alcohol and other drug or psychiatric treatment programmes. Canada's consistent success in reducing recidivism has been attributed to the gradual, supervised role these facilities play in rehabilitation and reintegration.[156]

For suggestions for expanding the range of community treatment options, see section 9.2.7.

7.4.5 Therapeutic jurisprudence

Therapeutic jurisprudence is a legal approach to improving the health of offenders while reducing their risk of reoffending, but without compromising standards of justice and community safety. It is an approach used widely overseas.

In England and Wales, the Bradley Report (a 2009 review of criminal justice, mental health, and learning disability services) has focused efforts on diverting people away from the criminal justice system whenever possible.[157] Their All-Stages Diversion model is a useful approach for effective diversion, which addresses each stage along the criminal justice pathway.[158]

New Zealand could make advances in therapeutic jurisprudence. Alternatives to the criminal court process have been functioning effectively for decades overseas through mental health courts, drug courts, and family violence courts. Thousands of drug courts operate every day in Australia, Canada, the United Kingdom, Jamaica, Bermuda, and the United States. New Zealand has only two initiatives, both reserved for young people: the Intensive Monitoring Group[159] in Auckland and Wellington and the specialist Youth Drug Courts in Christchurch.

7.5 Implement health-promoting policies and practices

Prisoners already have a disproportionate burden of health conditions when they enter prison. This burden is worsened by the physical, social, and institutional environments of prison (as discussed in section 5.3).

Attendees of the NHC workshop on prisoner health called for 'major shifts in attitude and culture'. According to participants, prisons should be seen as 'rehabilitative, not merely punitive'.[160] This was frequently echoed by families of prisoners:[161]

> From day one in there it should not be all about the rules and regulations, it should be about getting them some help. She has learnt nothing in there. Nothing has been offered to help her. Nothing much is done for people in there short term, but this is something that should be looked at.
>
> Parent of prisoner

The state has a responsibility to actively minimise the harms of imprisonment, protect the safety of everyone living and working in prisons, and improve the physical, mental, and social health of prisoners in preparation for their return to their families, whānau, and wider communities.

7.5.1 Current arrangements for public health approaches

The health sector is responsible for funding and providing 'public health' in prisons. Public health services promote and protect the health of populations through, for example, tobacco control, communicable disease control, immunisation, and other health protection programmes. The strength of relationships between public health units and local prisons varies, but is typically based on responding to infectious diseases.

The Department of Corrections and Ministry of Health have noted the shortfall in public health services provided in prisons compared with services provided in the wider community.[162]

The Department of Corrections is responsible for 'preventative' care services in prisons where such services impact directly on the department's primary health obligations and its strategic goals, such as 'safe, secure and humane containment'.[163] This is reflected in project work such as a communicable diseases screening, assessment, and treatment project undertaken at Christchurch Men's prison.[164] Other health-promotion activities in prisons and their outcomes are summarised in Appendix III.

The NHC calls for New Zealand to make its prisons health-promoting prisons.[165] The NHC believes this step, if carried out systematically, would improve health outcomes and lead a change in approach.

7.5.2 Health-promoting prisons

Making prisons health-promoting requires a broad spectrum of changes to the physical, social, cultural, and institutional aspects of prisons, alongside more traditional health education activities, to protect, promote, and improve health.

The World Health Organization's Health in Prisons Project[166] began in 1995 and has 25 participating member states. The project supports states to meet international standards for prisoner health. It has developed useful consensus statements about public health, mental health, young people, drug use, and HIV in prisons; developed guidelines for prison health care; and reviewed women's health in prison.

A 'health-promoting prison' focuses on:

- actively minimising the harms of imprisonment and improving safety for everyone living and working within prisons,
- building the health and resilience of prisoners
- respecting the dignity of every person in prison.

The Health in Prisons Project recognises that the health and wellbeing of prisoners is not the sole responsibility of those providing health care in a prison, but depends heavily on the regime and ethos of each prison. Therefore, a whole-prison approach to these activities with strong joint agency leadership is necessary.[167] This means everyone involved with the prison – management, custodial staff, health professionals, and prisoners – should be included and active in supporting a health-promoting environment. (See the example in Box 7.2.) This environment creates flow-on benefits to staff and their families and helps to reinforce support for a change in prison culture.

Box 7.2: 'Throughcare case management' model, ACT, Australia

A new prison in Canberra, the Alexander Maconochie Centre, follows a 'throughcare case management' model. This model encompasses training, education, rehabilitation, and work experience and establishes community support networks for prisoners before they are released.

As a health-promoting institution, the prison's key goals are that:

- everyone is and feels safe
- everyone is treated with respect as a fellow human being
- everyone is encouraged to improve himself or herself and is given the opportunity to do so through the provision of purposeful activity
- everyone is enabled to maintain contact with their families and is prepared for release.[168]

A true partnership, with staff from the Department of Corrections and Ministry of Health working together, is an essential first step to introducing and developing a health-promoting prison system.

Essential features of a health promoting prison are that:

- culture change is led from the top in both the health and corrections sectors
- genuine commitment, authority, and accountability accompany the top-down leadership[169]
- initiatives are workable and make sense to staff and prisoners
- prisoners' contributions to programme design and delivery are sought, valued, and put into practice
- prison staff and prisoners are included, valued, and respected
- prisoners are encouraged to maintain relationships with their family and whānau
- health programmes and service delivery follow best practice
- policies and procedures are regularly assessed for their impact on the physical, mental, and social wellbeing of everyone in the institution
- the wider threats to health and safety are addressed (as one prison health promotion expert points out, 'you can't expect people to think about quitting smoking when there are still assaults every day')[170]
- auditable frameworks, even modest ones, are developed.[171]

7.5.3 Health promotion opportunities

Opportunities exist for a variety of beneficial health promotion initiatives within New Zealand prisons in relation to the:

- physical environment
- social environment
- institutional environment.

Physical environment

Health promotion opportunities exist in relation to the physical environment of the prison in the areas of prison design, communicable disease control, chronic disease control, and health education.

Prison design

A living and working environment that is warm and dry, with fresh air circulating and access to sunlight, exercise spaces, and open, green spaces is a simple and effective way to promote hygiene and the physical and mental health of everyone within that environment. Prisons that are designed with health and disability as well as custody in mind will promote the health of staff and prisoners and, ultimately, will make the job of the Department of Corrections easier. Some prisons in Scandinavia have even built in savings in both electricity and health costs by creating energy- and heat-efficient 'green prisons'.

As the prison population ages, the particular housing needs of older prisoners, including those with chronic conditions, needing palliative care, or with mobility or disability concerns, are necessary considerations when investing in prison architecture. This population is likely to grow even further with recent legislative change, and many of New Zealand's current facilities are not environments conducive to promoting health and independence. Demands on both corrections and health staff are likely to increase if the health and disability needs of older prisoners are not planned for now.

A purpose-built health-promoting prison is likely to be the most cost-effective type of prison. The NHC encourages the government to consider how health and disability needs as well as security needs can be integrated into the design of new and renovated prison buildings and grounds.[172]

Communicable disease control

Prisons are an important venue for identifying and treating communicable disease. In October 2009, representatives of 65 countries and experts in prison health and public health issued The Madrid Recommendation.[173]

The Madrid Recommendation cites the 'urgent' need for measures to limit the spread of communicable disease within and from prisons. Recommended measures include:

- alternatives to imprisonment
- treatment programmes for drug users according to assessed needs, resources, and national and international standards
- harm-reduction measures, including opioid-substitution therapy, needle and syringe exchange, and the provision of bleach and condoms
- guaranteed throughcare for prisoners on entry to and after release from prison
- mental health support, especially to prisoners suffering from communicable diseases
- training of all prison staff in the prevention, treatment, and control of communicable diseases.

In 2007, the Department of Corrections and Ministry of Health agreed on funding and protocols to establish a hepatitis B immunisation programme. This programme now runs in all New Zealand prisons. In 2010, the Ministry and the Department agreed on case management protocols for outbreaks of tuberculosis in prison.[174]

A good example of collaboration in communicable disease treatment is found in Waikeria Prison (see Box 7.3).

Box 7.3: Collaboration in communicable disease treatment, New Zealand

Concern about a prevalence of hepatitis C in the local community and a highly motivated prison nursing team led Health Services at Waikeria prison and Waikato hospital's gastroenterology team to develop a shared care model to support monitoring and treatment of men in prison with the hepatitis virus. This initiative was a finalist in the Waikato DHB's new collaboration awards in 2008.

Together the team developed protocols for hepatitis B and C. This enabled the Waikeria nurses to manage and support these prisoners through their diagnosis and treatment. It was agreed that on-site clinics would be facilitated by the gastroenterology team. This means substantial savings to the Department of Corrections in custodial officer time and transport costs.

Not all DHBs offer this service, so only men who will be at Waikeria for the duration of treatment are accepted. Prisoners with the virus are encouraged to enrol (and most do) with the Hepatitis Foundation for regular monitoring of their liver functions on their release from custody. Monitoring is needed because there is a risk of hepatocellular cancer developing, if the condition remains untreated.

The programme has had unexpected spin-offs: 'The prisoners talk to their families about it – they become quite passionate, passing on the information they have received from the education sessions provided, telling their families "you can get it this way". A family member rang us to ask if there's anything else they can do to protect their children.' Nurses are proud of the programme and patients are reportedly excited to begin treatment.

Every man who has entered the hepatitis C treatment programme at Waikeria Prison has been cured.[175]

A harm minimisation pilot in 2003 introduced bleach for cleaning needles, condoms, dental dams, and health information into Rimutaka Prison and Arohata Women's Prison. The pilot was considered successful, but it was not implemented around the country. Today, prisoners may ask for one or two condoms and may request sexual health and drug information from a nurse.

The NHC strongly urges the introduction of a comprehensive harm-minimisation approach to the transmission of infectious diseases in all New Zealand prisons.

Some jurisdictions have developed fresh ideas for reducing the risk of disease spread (see Box 7.4).

Box 7.4: Innovative communication strategies for harm minimisation, England and Wales

Health promotion experts in England and Wales have pioneered innovative methods for communicating risks and safe behaviours to prisoners at risk of blood-borne diseases.

One method is a deck of playing cards that is freely available to prisoners. The cards have pictures and traffic lights that illustrate the importance of sterilising tablets for needles, condoms, and

other harm-minimisation supports. The cards contain little writing, so prisoners' literacy levels are less likely to be a barrier to understanding.

Another method is an award-winning DVD, *Inside and Out*, about hepatitis C symptoms, prognosis, prevention, management, and treatment. Prisoners and injecting drug users share their stories and answer common questions in a forthright, realistic video. Its originator says, 'We wanted our DVD to be empowering so we decided no doctors or nurses – have a knowledgeable voice, but otherwise have prisoners showing how you cope'.[176]

Chronic disease control

Many opportunities exist to prevent or slow the onset of chronic conditions. Because of the extremely high smoking rates among prisoners, in-prison smoking cessation programmes should be given greater support and smoke-free environments provided for those who do not smoke or who want to quit.

One successful example is a joint venture by the Quit Group and the Department of Corrections, funded by the Ministry of Health. The Quit Group trained corrections nurses to initiate smoking-cessation services to prisoners. Aukati Kai Paipa, a Māori Quit Group programme, is also under way. This joint venture has significant potential for producing health benefits, reducing health inequalities, and limiting costs to the health sector in the long term.

Health education

Many of the risks related to the prison environment, including harms and risks of drug use, are important areas for extended effort in health education.[177] Essential health knowledge could be included in the literacy and numeracy programmes available to prisoners.

A successful health promotion and education project in a prison is summarised in Box 7.5.

Box 7.5: Health promotion diary, England

At Her Majesty's Prison Garth in England, a team of 10 prisoners was recruited to work with health providers to create a 12-month health-promotion diary. A competition produced original prisoner artwork and written contributions.

The diary features articles aimed at supporting first-time prisoners and others. The articles outline the effects of alcohol, other drug, and caffeine use; hepatitis; anger; and common mental health problems. The diary includes coping strategies and techniques to support self-recovery, along with mental activities and in-cell exercise workouts. Organisations that support prisoners and their families advertise on the pages of the diary.

The project's organisers believe the health-promotion diary helps prevent prisoners' health deteriorating during custody, promotes rehabilitation and engagement with health services, and promotes healthy behaviours that can be applied when prisoners' return to the community.

The World Health Organization awarded the project a Health in Prisons Project Best Practice Award in 2005.

Health promotion and health education efforts are important, but they must not be carried out in the absence of institutional change. Institutional change can support individuals' efforts to change. It signals good faith and an honest appraisal of the multifaceted nature of many of the health problems that prisoners encounter.

Social environment

Opportunities exist to improve the social environment of the prison in relation to assault, rape, and other forms of harassment. Assault, bullying, and rape in prisons are commonly and grimly regarded as an inevitable part of prison life, but this need not be so. Sexual harassment and rape in prison have been shown to be preventable in well-run prisons.

After six years of research and consultation, the National Prison Rape Elimination Commission in the United States produced standards for detecting, preventing, and responding to prison rape.[178] The standards describe how to:

- implement education for staff and prisoners
- implement mandatory reporting and incident reviews
- identify at-risk prisoners and take that risk into account when housing prisoners
- protect individuals against retaliation
- improve surveillance
- take immediate care of rape victims.

The key to making such policies work is management sending a clear message that any abuse or harassment by staff or prisoners is unacceptable and that every incident will be taken seriously.

Priority should be given to ensuring the environment in New Zealand prisons is not conducive to sexual abuse or harassment by staff or prisoners.

As a first step, the NHC proposes a review of policies and procedures against sexual abuse and harassment to determine how New Zealand prisons can meet the National Prison Rape Elimination Commission's standards. The NHC believes this approach has the potential to reduce the number and seriousness of non-sexual assaults in prisons as well.

Institutional environment

There are opportunities to reduce the negative effects of the institutional environment in prisons.

Mental health and social inclusion

Prisoners' mental health may deteriorate in prisons in part because they feel ashamed for what they have done, but are powerless to do anything as restoration. Mental health promotion initiatives could give prisoners an opportunity to do something meaningful for their families and whānau or communities. Prison should also be an opportunity for people to be supported toward social inclusion both within the prison environment and on release.

Emotional resilience and social inclusion are enhanced by:

- restorative justice measures
- opportunities to reflect, take stock of one's life, make healthier choices, and practise social skills
- regular physical exercise, spiritual reflection, meditation, or martial arts
- regular participation in education, work, or training
- regular contact with family and whānau
- artistic expression
- anti-bullying strategies in the prison system
- depression-prevention strategies
- skills and coping strategies, including peer-support programmes, that use prisoners' own resources.

The value of engaging prisoners to assist others in the prison is described in Box 7.6.

Box 7.6: Listener programme, Scotland

In the Scottish Prison System, the value of engaging prisoners to assist others within the prison while building their confidence is well recognised. The Listener programme is a good example. The Samaritans (a community-based non-governmental organisation) trains screened prisoner volunteers to be active listeners. Prisoners who are feeling down may ask for help by phone, and a listener will usually visit them the same day.

The programme is well received and has relieved some of the burden on the prisons' mental health teams. The programme has also boosted the self-esteem and skills of the listeners. The NHC was told that listeners often move into helping occupations after prison. More than 1,000 people have become listeners through this programme.

An extension of the concept to allow long-term prisoners who care for others with disabilities to train for and receive recognised qualifications in care assistance is being explored.[179]

The Auckland Region Women's Corrections Facility has partnered with Mobility Assistance Dogs to pilot a dog-training scheme, the Puppies in Prisons Programme. The programme shows promise on several fronts. Participants are fully occupied, so are less tempted to break rules or take drugs. Participants also develop self-belief, a sense of redemption, and hope, knowing they are contributing to the community and developing skills that will serve them well on release.

The women reported gaining insights into parenting by working with the energetic dogs. Mobility Assistance Dogs is delighted with the results, saying:[180]

> If we had every prison in New Zealand training or rehabilitating dogs, we wouldn't have such enormous problems supplying disabled people with mobility dogs.

Suicide prevention

The NHC's findings echo studies from abroad that show the lengths prisoners will go to to hide their feelings to avoid being placed in an isolation unit.[181] This places all prisoners and staff at more risk from the fall-out of unaddressed mental health problems.

Prisoners regard at-risk units (commonly used as a response to those at risk of taking their lives) as punishment:[182]

> I needed time out. Somewhere quiet, peaceful and safe. But there's only [the at-risk unit] ... an empty room with no stimulus. It makes you go crazy. It's a punishment. You lose all privileges. After your first time you do everything you can to avoid it in the future.
>
> Siaki, Pacific man, 20–30 years

Seclusion units are being phased out in other jurisdictions,[183] because their negative effects on existing mental health conditions are well understood. In New Zealand the Mental Health Commission has recommended the use of seclusion be eliminated as far as possible and monitoring of its use be strengthened.[184]

The NHC supports efforts to train prison officers[185] as partners in a whole-prison response to suicide risk, to detect signs of mental health deterioration (see also section 9.2). A prison-wide approach to suicide prevention minimises risks without violating human rights.

The NHC supports a full review of at-risk units. The review needs to focus on how to prevent suicide and improve mental health outcomes; develop alternative interventions for inmates in crisis; identify a path toward the phase-out of seclusion; and identify appropriate means for managing other types of risk (including behaviour, protection, segregation, and withdrawal and detoxification). The review should explore methods used in other countries for managing each type of risk. The review team should include mental health professionals.

An alternative model for minimising risk is described in Box 7.7.

Box 7.7: Alternative model for minimising suicide risk, Scotland

The Scottish prison system aims to maintain at-risk prisoners' sense of control and familiarity with their surroundings. It has designed cells without risk points,[186] so at-risk prisoners can remain in their own cells (and their own clothes).

The prison system convenes multidisciplinary weekly meetings with prisoners who have mental health problems. When a prisoner is considered at risk of suicide, family members of his or her family are invited to attend the meetings, with the patient's consent.

Scotland's prison suicide rate is no higher than New Zealand's.[187]

7.6 Involve prisoners in designing prison health and disability support services

7.6.1 Patient involvement improves effectiveness

It is essential that people with first-hand experience are actively drawn into and involved in policy-making decisions and processes. Throughout the NHC's investigation, the importance of patient involvement in the design of health services and promotion was repeatedly highlighted.[188] This principle is established within the Health and Disability Services (Core) Standards and the objectives of the Primary Health Care Strategy. It is also recognised across the social services sector as a means of improving the relevance, participation, and effectiveness of services.

Participants in the prisoner health workshop reminded us that prisoners and their families and whānau often regard authorities with suspicion, distrust the purpose of procedures 'imposed' on them (procedures that are designed to meet the needs of the criminal justice system), and are unlikely to gain from attempts at health promotion without some trust building. Rather than seeing patient groups as 'hard to reach', this perspective sees services as 'hard to trust'.

Trust can be built by genuinely encouraging the involvement of prisoners in all areas of policy development, implementation planning, and peer support. As prisoners and former prisoners told the NHC, 'we know what works and what doesn't'.[189] Family and whānau also have useful insights into areas such as visiting arrangements, parenting support, reintegration, and continuity of care (see sections 9.3 and 11–13).

The recovery philosophy that underpins mental health and addiction services for New Zealanders recognises that:[190]

> service users must lead their own recovery, have personal power and a valued place in their whānau and communities. [There is also a] recognition that family and whānau must be involved in service delivery and treatment.

Around the world, numerous examples exist of good practice in prisons using patient involvement in service design and delivery and encouraging self-management. See the example from Belgium summarised in Box 7.8.

Box 7.8: Patient involvement in service delivery, Belgium

The Peer Education Programme of Belgium's Jamioulx prison uses an expert non-governmental organisation (Modus Vivendi) to train prisoners to act as peer educators in the field of HIV and hepatitis prevention. The programme was informed by research that confirmed low levels of knowledge about risk among injecting drug users and that 'insiders' are the most effective agents to deliver health messages within a 'hidden population'.

'Health agents' educate their peers about blood-borne disease risks, prevention, and harm-minimisation methods. Five health agents reached 35 injecting drug users with the information.

Benefits from the programme have included:

- heightened drug-harm and harm-minimisation awareness among identified drug users

- improved procedures for transferring drug users in treatment to external services when released
- more knowledgeable prison health staff
- health agents being able to directly deliver and discuss with prison staff suggestions for improving treatment and follow-up of drug users
- health agents being motivated by the opportunity to play a useful role in the lives of others and being 'immensely proud' of their achievements.[191]

In addition to important first-hand experience, leadership exists within the prisons and among prisoners' families and whānau. Agencies need to recognise that leadership and foster it to work toward improving access and reducing health inequalities for every community – in or out of prison.[192] See an example of such leadership in Box 7.9.

Box 7.9: Notorious chapter leadership collaboration with Salvation Army, New Zealand

In October 2009, the Salvation Army and the Auckland chapter of the Notorious Mongrel Mob ran a successful pilot rehabilitation course aimed at helping members stay off 'P' and other substances. Ten Mongrel Mob members and their families stayed at Ruapehu Christian Camp in Kakahi, King Country, for seven weeks.

The programme was successful, says a member, because the Salvation Army listened to and worked with Notorious leaders to tailor the programme to the needs of this community. The programme includes a basic life skills training course and a tikanga element, and family members are encouraged to stay and be involved – with tamariki even enrolling at the local school.

Those who took part were emphatic in their appreciation for the scheme's respect for the families and the emphasis on family support in helping people stay off drugs. The hardest part for those who took part was re-entering their communities. Some planned to move towns to ensure the continuation of new habits.

Recommendations

The NHC recommends that to improve the health of prisoners and their families and whānau:

1 Agencies providing health services and disability support to prisoners adopt the following principles:
   a adhere to the principle of 'equivalence of care based on needs' to ensure prisoners receive the same standard of care in relation to their needs as is available in the wider community
   b align health care in prisons with existing health legislation
   c ensure policies and procedures affecting prisoners are driven by the principles of Whānau Ora
   d take a prevention and care approach to prisoners' health conditions and disabilities (therapeutic approach)
   e implement health-promoting prison policies and practices
   f involve prisoners and, where possible, their families and whānau in designing prison health and disability support services.

8 Improve planning

Considerable improvements can be made to the health and wellbeing of prisoners and their families. Two important first steps are in the way agencies plan.

Government agencies need to:

- assess the potential effects of new policy on the health and wellbeing of prisoners and their family and whānau before policy implementation.
- report regularly on the health and disability status of the prison population and use those reports to ensure service delivery is adequate to meet the identified needs of the prison population. This is especially important for mental health, alcohol and other drug addiction, and oral health needs.

8.1 Assess the potential effects of new policy on prisoners and their family and whānau

Policies that do not necessarily have a health focus, and even those that do, when implemented, can have unexpected consequences for health. Policies that directly affect prisoners, prison staff, or the family and whānau or visitors of prisoners can emerge from any of several government agencies, and need to be assessed for their potential health impacts before they are implemented. This assessment will ensure positive health effects can be enhanced and negative effects can be eliminated or mitigated.

This assessment would improve policies for, for example, housing prisoners, designing a new visiting centre and visiting procedures, or adding bunks to cells. The unique aspects of prison culture are also an integral part of this assessment and the best way to consider those aspects is to involve service users in assessment processes.

New Zealand resources have been developed to assist the policy-assessment process and include tools for health impact assessments[193] and Whānau Ora health impact assessments.[194] The NHC endorses the use of these tools to assess the effects of new policy and protect against unintended negative health consequences.

8.2 Report regularly on the health and disability status of the prison population for service planning

To effectively identify priorities for health care and disability support services for prisoners, the agency responsible for primary health care in prisons needs to regularly review the health and disability status of the prisoner population.

Processes for health needs assessments to monitor the prison population's health status relative to that of the non-prisoner population have been established. For example, the Toolkit for Health Care Needs in Prisons (UK) covers basic demographic and health status data, identifies areas of unmet need, and identifies services available and rates them by their effectiveness.[195]

The NHC suggests the assessment process includes direct input from the prisoner population.

Service planning is fundamental to any high quality health care system. Service planning for the prison health system based on the best information available about health and disability needs, projections, and current service deficiencies will ensure that services are consistent across locations, an appropriately skilled workforce is efficiently deployed, and the services are equivalent to those available to the wider community. Planning for the needs of groups with particular health needs, such as older prisoners, is particularly important as their numbers within the prison population continue to grow.

Health and disability status reports for the prison population should be used, in conjunction with an analysis of available workforce, to:

- support workforce planning
- support service planning and improvements
- compare service provision between prisons
- help planners to limit costs (through regional or national purchasing)
- assist in monitoring equivalence of care based on needs.

Government agencies responsible for the health and disability needs of prison populations should co-operate to ensure service delivery is adequate to meet the identified needs of the

prison population, particularly in the areas of oral health, mental health and alcohol and other drug dependence and addiction. See also section 9.1.6.

Recommendations

The NHC recommends that to improve the health of prisoners and their families:

2 Government agencies, when proposing new policies that may affect the health of prisoners, staff, families or visitors, are required to consider the potential effects on their health and wellbeing.

3 The agency responsible for primary health services in prisons regularly reports on the health and disability status of the prison population and uses these reports to ensure service delivery is adequate to meet the identified needs of the prison population.

9 Strengthen service delivery

To strengthen health services delivery, the agency responsible for primary health care and disability support services in prisons needs to improve the quality of primary health care in prisons (see section 9.1), strengthen the identification, assessment, and treatment of health conditions and disability support needs of prisoners (see section 9.2), and ensure seamless continuity of health care for prisoners entering, transferring between, and leaving prisons (see section 9.3).

9.1 Improve the quality of primary health care in prisons

Consideration of a transfer of accountability for prisoner health services from the Department of Corrections to the Ministry of Health is the key recommendation of this report (see section 10.2).

It is also the NHC's view that improvements to primary health care for prisoners (including public health services to prisoners in the prison primary health care setting) are achievable now, whether or not this transfer occurs.

9.1.1 Development of primary health care in prisons

Since 2001, reviews of health services and workplace development have found that the health services provided by the Department of Corrections have fallen short of the standards established by the Ministry of Health and available to the non-prison population.[196] Problems include:

- prison health services that are not well defined or recognised within the prison service
- a lack of consistency and national coordination
- quality standards that do not match the standards in the health sector
- inadequate funding and no mechanisms to ensure ongoing adequate funding

- inconsistent arrangements with external providers
- low levels of nursing availability
- delays in prisoners being seen by a general practitioner and unacceptably short general practitioner consultation times
- an absence of strategic leadership and no staff and service development focus
- a lack of a Māori approach to health services
- communication difficulties between health and custodial staff
- no information systems for health management, data sharing, or analysis
- inconsistent stocks of vital medical items and equipment.

Most of these problems were attributed to the failure of funding to cover the costs of a dramatically expanding high-needs prison population.

The Department of Corrections has put the following measures in place to address these deficiencies:

- developing Prison Health and Disability Support Service Specifications
- establishing a clinical reference group to assist in developing a health services manual
- establishing a clinical governance structure headed by a national health manager and national clinical director
- adding quality assurance, nursing, and administrative roles
- enhancing health workplace development policies
- developing communicable disease management protocols
- redeveloping the reception health assessment tool
- developing new procurement procedures
- installing primary health care medical records software (MedTech) in each clinic.

9.1.2 Governance of prisoner health services

Prison health services are largely governed by a memorandum of understanding between the Department of Corrections and Ministry of Health and the Prison Health and Disability Support Service Specifications.

Memorandum of understanding

The memorandum of understanding between the Department of Corrections and Ministry of Health was agreed in 2004 and sets out the expectations and responsibilities between the two agencies for the delivery of health services to the prison population (see section 6.1.3). The memorandum has improved understanding about areas of departmental responsibility.

However, the memorandum has not clarified responsibilities in some key areas. Alcohol and other drug assessment and treatment, some mental health issues, public health, pharmaceuticals, and disability supports are areas in which disagreements remain or responsibility is unclear.

The memorandum also does not include the Accident Compensation Corporation.

Prison Health and Disability Support Service Specifications

The strategic and compliance documentation guiding the delivery of prison health services now draws significantly on the standards guiding the public health system. The Prison Health and Disability Support Service Specifications provide the operational policy framework to ensure health services delivered in prisons are aligned with and linked to the Ministry of Health's Service Coverage Schedule, the primary health organisation contract description, and the Health and Disability Services Standards.[197]

More recently, the Department of Corrections has developed policies and procedures for the continuous improvement of the quality of prison health services. Quality improvement activities are documented and implemented annually. However, implementation of the Prison Health and Disability Support Service Specifications and quality improvement activities remains inconsistent across prisons and regions.

Working groups – Health Advisory for New Zealand Offenders Network

When the memorandum of understanding was concluded, a joint oversight group was agreed to regularly bring together representatives from the Ministry of Health, the Department of Corrections, and DHBNZ. This group has evolved into the working groups HANZOFF, which maintains a strategic overview, and HANZON, which has an operational focus.

HANZOFF has met about once a year, but HANZON meets more regularly to collaborate on areas of mutual interest such as mental health and addiction services and projects.

9.1.3 Service delivery arrangements

The Department of Corrections is responsible for funding and delivering all primary health care to prisoners, including medical and nursing assessment, treatment, and care; disability support; primary mental health services; pharmaceuticals; cervical screening; emergency health; oral health; and health education and advice for individual prisoners. The department employs nurses and contracts general practitioners, dentists, and other service providers to deliver these services.

The Department of Corrections provides nurse-led health services in 20 prisons around the country. Every prisoner receives a reception triage on their entry to prison followed by a primary health assessment. On average, prisoners receive more primary care consultations each year, particularly with nurses, than do members of the wider community.[198] International research suggests it is typical for prisoners to have higher consultation rates than non-prisoners.[199] However, compared with the wider community, prisoners have

disproportionately high health needs and in-prison consultations include minor pain relief, cuts and abrasions, and other low-level needs. Prison nurses spend up to a quarter of their work-day distributing medicines.

Maternity services are the responsibility of the health sector.

The Accident Compensation Corporation funds some primary health care services to prisoners, and other services in prison are provided by contracted third-party providers. These providers range from larger organisations providing state-funded services (eg, the Problem Gambling Foundation) to smaller non–state-funded agencies (eg, Te Oranganui Iwi Health Authority, which provides an alcohol and other drug service to Kaitoke Prison in Whanganui).

9.1.4 Challenges for the primary health care service

The NHC commends the Department of Corrections for the changes it has made in its health services in recent years and believes it has improved functioning, moved health delivery in the corrections sector closer into line with delivery in the health sector, and helped to elevate the role of the health service in the Department of Corrections. Nevertheless, New Zealand prisons struggle to meet the standard of equivalence for primary health care with the community primary health care sector.

Prison health service delivery also has intrinsic challenges. Ongoing challenges to providing primary health care services equivalent to those provided to the wider public are in the areas of standards, the workplace and workforce, the provision of appropriate services, and access.

<u>Challenges in standards for health care services</u>

Challenges in standards for health care services include the following.

- Services in prison are provided in an environment dominated by a focus on security. Health care staff must be able to treat people primarily as patients, rather than prisoners, when carrying out their duties.[200]
- Many prisoners regard the primary health care services they receive to be of a lower quality than those provided to the public.[201]
- Standards for service delivery should be set higher than simple procedural compliance. A focus is needed on improving health outcomes for patients,[202] achieving Whānau Ora outcomes, and reducing health inequalities.
- Services need to respond to the health and disability needs and cultural perspectives of the populations they serve.
- Policy and procedure need to be implemented consistently in dispersed locations, each with its own local operational constraints (and culture).
- The provision of health services within a prison requires the active participation of corrections officers. Strong working relationships between prison health staff and corrections staff are essential.

- Regular collection and analysis of health status and service delivery measures must underpin the measurement and improvement of quality.

Challenges in workplace and workforce

Challenges in the workplace and workforce include:

- Clinical teams must be well managed and adequately staffed to allow consistent and continuously improving service and to enable thorough clinical oversight by team leaders.
- The recruitment and retention of health professionals to prison work continues to be a challenge in some areas. Contracted services can be expensive, particularly in more remote prisons. The recruitment and retention of Māori and Pacific health professionals is particularly problematic.
- A strong focus is on nurse-led practice with relatively limited involvement from other health professionals.
- Some services rely on cooperation from external agencies (eg, public health services, support for mental health services, alcohol and drug treatment).
- External providers face barriers to entering prisons.

Challenges in provision of appropriate services

Challenges in the provision of appropriate services include:

- Cultural competence among the health workforce is variable.
- Few Māori and Pacific providers deliver services in the prisons.
- There are logistical difficulties in involving the family and whānau of a prisoner in the health care of that prisoner.

Challenges in access

Challenges in access include:

- Prisoners are not able to get to the prison health centre on their own initiative; they must make a request and wait to see what happens.
- Prisoners are not able to see a doctor unless the nurse believes a consultation is warranted.
- Prisoners are not able to choose who provides their health care, so in most cases they cannot, for example, opt for a Māori or Pacific provider or switch providers.
- Continuity of care is compromised because of frequent inter-prison transfers.
- Staff shortages or crises in the prison can interrupt or delay in-prison treatment.
- Prisoners miss appointments when corrections staff are not available to escort them.

9.1.5 Opportunities to improve primary health care in prisons

There are opportunities to improve how primary health care is delivered in prisons by: addressing health needs while a person is in prison; in the changing focus for the health sector; and relating service delivery to Government health targets.

Opportunity to address health needs while in prison

Prisoners represent one of the highest-needs, highest-cost population groups for health services. However, prisoners are a 'captive audience', so many of the hurdles for achieving access to health care among high-needs populations do not exist. This is an advantage for service provision as well as a potential savings in health expenditure as prisoners are released with health conditions resolved or better managed. It is also a significant opportunity for the health sector to support the prison service to reduce health inequalities (eg, by offering public health services and health education within prisons and by extending existing mental health, alcohol and other drug services to prisoners).

Opportunity in the changing focus for the health sector

The environment in the health sector is characterised by a new focus on changing the way health and disability services are provided to create financial sustainability in health expenditure. In July 2009, the Ministerial Review Group made recommendations to deliver public health and disability services within a more sustainable and slower path of health expenditure growth.[203] The Ministry of Health and DHBs are implementing these recommendations, which have a strong focus on prioritising and rationalising resources in planning, funding, and health management.

The Ministerial Review Group also noted several challenges, including balancing workforce needs and national and regional services. Opportunities exist for the Department of Corrections and health agencies to use existing resources more efficiently and develop stronger alliances by reconfiguring health services to better meet population needs.

An example of strong collaborative practice is an initiative linking Christchurch Women's Prison with the local college of midwives. Midwifery students enter the prison to provide antenatal care. Many prisoners' pregnancies are high-risk, and this visit may be a prisoner's first access to an antenatal care provider. The programme links women with post-release primary health care and regular Well Child services, and introduces midwives (and their influence) to a practice venue they would not otherwise have been exposed to.[204] The work of the Quit Group within prisons is another example of strong collaborative practice.

It is too early to provide conclusive results in these areas, but these collaborative initiatives between the health and corrections sectors could be propagated as models to improve the effectiveness of other public health and primary health services in prisons.

Other key government objectives, in the areas of Whānau Ora and Addressing the Drivers of Crime, also represent significant opportunities to address the needs of prisoners and their families and whānau through a wider intersectoral focus. The importance of ensuring Whānau

Ora initiatives include prisoners and their families and whānau is highlighted in Part Three (sections 11–13).

Opportunity to relate service delivery to health targets

No financial models identify the flow-on costs and effects of poor prisoner health to the health sector. However, the population of prisoners and their families and whānau represents a key component of the population to whom government health targets are aimed.

The relevant government health targets are:

- better help for smokers to quit
- better diabetes and cardiovascular services.

Roughly two-thirds of prisoners are current smokers, over 50 percent are overweight or obese, and men in prison have higher self-reported rates of heart disease and chronic obstructive pulmonary disease than the non-prison population (see Table 4.1).[205] The NHC endorses the smoking-cessation efforts of the corrections health service and its plans to implement cardiovascular disease risk assessments for prisoners with a risk factor.

Preventive measures, good public health promotion, and early intervention through effective primary health care services save lives, reduce future costs for the tertiary and secondary health sectors, and reduce health inequalities.

9.1.6 Achievable improvements in quality

Until the responsibility for primary health care to prisoners rests with the health sector, the standard of health care provided to prisoners should be benchmarked against the standard of care provided by the rest of the New Zealand health service.

The NHC has identified remedies to strengthen existing practice and improve the quality of prison health services that can be undertaken in the near term. These remedies are:

- multidisciplinary teams
- improved training and development for prison health professionals, particularly nurses
- stronger professional support for prison health professionals, particularly nurses
- a higher quality of service provision through:
  - accreditation
  - independent audit
  - clinical pathways
  - the monitoring and evaluation of services
- monitoring, planning, and information sharing – the collation and analysis of primary health care data for monitoring health status and effective service planning, information, and data sharing.

Multidisciplinary teams

The high and complex health needs of the prison population demand a variety of clinical and non-clinical expertise. A multidisciplinary health care team is required to provide comprehensive assessment and provision of care.

A well-managed multidisciplinary team can optimise the skills of its members and facilitate good case management.[206] The contributions of the general practitioners in the prison clinic team, for instance, can enhance team function, care planning, and cross-discipline learning. A multidisciplinary team approach would mean the right skills are brought to bear, professional support is strengthened, and health workers' understanding of the conditions their patients are experiencing will deepen.

An example of an award-winning multidisciplinary primary health care team in a high security prison is summarised in Box 9.1.

Box 9.1: Multidisciplinary practice with patient involvement, England

At Her Majesty's Prison Full Sutton in England, a wing-based nurse offers health promotion advice and provides an annual health screen to all prisoners, giving them an opportunity to discuss any health concerns. The nurse refers patients to lead nurses in asthma, diabetes, chronic obstructive pulmonary disease, obesity, sexual health, blood-borne diseases, chronic heart disease, smoking cessation, immunisation, and pain management. The primary health care team works closely with prison officers, chaplains, the education department, drug services, physical education instructors, visiting consultants, art therapists, and psychiatrists.

A team of mental health nurses works closely with the substance abuse team, and trains prison officers to work with personality disordered prisoners.

A day care service provides sessions on mental health awareness, coping strategies, dealing with voices, relapse prevention and early warning signs, stress-reduction strategies, and managing bullying. Patients may be followed up for individual work such as cognitive behavioural therapy. A newer elderly day service provides health and social care to prisoners over the age of 60.

Before the programme, prisoners believed they would not receive thorough interventions. Because prisoners played a significant part in the service design, evaluation, and improvement, the service gained information about 'user friendly' delivery modes and confidence in the service grew among patients.

Other benefits have included an increase in prisoners' self-esteem, a significant reduction in self harm, and improved self-management. Project leaders advise, 'Use this opportunity for prisoners to take a key role in promoting health and raising the profile of health care amongst prisoners'. The project was awarded a Health in Prisons Best Practice Award in 2007.[207]

Rehabilitation practitioners could significantly improve health and disability outcomes for prisoners. The NHC believes this area of health need is greatly under-resourced in the current system. For instance, some prisoners with an intellectual disability, a mild to moderate mental illness, or a learning disability could benefit from occupational therapy to adapt to the routines and constraints of prison life and to develop social and survival skills in prison. After release, these prisoners need support to develop structure, confidence, vocational skills, and daily living

skills. The absence of these skills heightens the risk of worsening mental health and therefore reoffending. This is particularly likely for long-serving prisoners and others released without any or sufficient support.[208]

The recruitment of nurses, doctors, and other health professionals has been a persistent challenge, particularly in remote locations. Recruiting Māori and Pacific health professionals continues to be a priority, particularly as the proportions of Māori and Pacific prisoners are large and they have particular cultural needs. This problem demands focused attention in the context of the related concerns of health workforce development and corrections as a working environment for Māori and Pacific people.

The process of developing the right workforce mix for the prison primary health care service would see workforce planning for multidisciplinary teams that responds to the regular reviews of prisoners' health and disability status (see section 8.2). Specialist skills and experience can be shared across a region or across the country.

> The NHC envisages an incremental approach to workforce change, as related decisions about preferred models of care, clinical pathways, and continuity of care processes are made.[209]

Improved training and development for prison health professionals

Primary health care delivery in prisons is different from delivery in the wider health sector. Prison nurses have a wide scope of practice, because they operate reasonably autonomously, encounter significant and co-existing health conditions prevalent in prison,[210] and have patients who live in a physically dangerous and mentally challenging environment.

Hidden and intellectual disabilities can be particularly difficult to identify. Intellectual disability assessors the NHC spoke with noted that nurses who had moved into prisons from closed psychopaedic hospitals made more knowledgeable referrals as result of their experience. The NHC noted that corrections health staff need training on eligibility, care and referral pathways, and processes for disability services and supports, which may be available through Disability Support Services at the Ministry of Health, from the Accident Compensation Corporation, or direct from a range of non-government providers and associations.

New Zealand's prison nurses have a core training programme, which includes a three-day introduction to primary mental health. New graduate training for nurses in prisons has recently become available, but prison nurses are not currently eligible for Clinical Training Agency funding because they are not part of the health sector. New graduates may take placements in prison clinics through a Nurse Entry to Practice expansion programme through the local DHB. Preceptoring, which lasts six weeks in other venues, takes three months in prison clinics. After the three months new graduates are expected to be able to act confidently on their own. One preceptor said 'It can be very difficult. Your first year nursing and your first year working for corrections; it's like learning two different languages at the same time'.[211]

The New Zealand Nurses Organisation offers medico-legal training for prison nurses to prepare them to manage the high level of risk they experience. This includes ethical decision making, medication management and documentation, and risk management.

The World Health Organization has identified requirements for prison health staff:[212]

> [Prison health staff] should start from a basis of professional training in which issues such as confidentiality, patient rights and human rights have been fully covered and discussed. They should also have some knowledge of epidemiology, of how diseases spread and of how lifestyles and socioeconomic background factors can influence ill health. They should also be aware of human nutrition and of the importance of exercise and fresh air in promoting health. They should be alert to potential threats to health and able to detect early signs of mental health problems.

The prison health workforce needs access to ongoing postgraduate training. This training should include refresher or focus components such as:

- effective multidisciplinary team functioning
- advanced assessment and referral skills
- identifying, understanding, and responding to the health conditions and disabilities most prevalent in prisons, particularly mental health and alcohol and drug dependence and addiction
- appropriately identifying, interpreting and responding to the behaviours associated with these health conditions and disabilities
- maintaining a high standard of medical ethics within the unique organisational constraints context of practice within prisons
- medication management
- understanding multiple cultures (particularly of Māori and Pacific peoples) communicating effectively, and responding to their needs
- public health, communicable disease control, and health promotion
- chronic conditions management and support for self-management
- involvement of family and whānau in care planning and maintenance.
- managing the emotional impact of working in the prison environment.

<u>Stronger professional support for prison health professionals</u>

The prison working environment is acutely challenging. Health professionals working in prisons regularly face ethical dilemmas their counterparts in the community may see rarely. These dilemmas include strong feelings about the nature of a patient's offence, conflicts between clinical and custodial requirements, and difficult or threatening patients.[213] Many of these patients are also talented at manipulating people and systems for their benefit. Questions of trust are magnified in prisons and for those living or working within them, and it can be hard to know who to believe.

> They're just too used to dealing with junkies to help someone who genuinely wants to come off.
>
> Michael, Pākehā male, 18–25 years (interview)

Prison nurses, in particular, act as gatekeepers to the health system and have significant responsibility in a high-pressure environment. Patients may present with any combination of emergency wounds, hidden disabilities, psychiatric disorders, infectious diseases, addiction, or withdrawal issues. Prison nurses often may feel isolated or overlooked in the nursing workforce and its professional organisations and associations.

To manage risk within the workplace, prison nurses require clear, consistent policies and procedures particularly for medication management and for carrying out verbal orders from doctors. Doctors, particularly those new to prison work, also face high clinical and emotional demands. All health professionals working within prisons require strong orientation, clinical support, institutional protections, support for professional development and options for mentoring or supervision to prevent unsafe practices and manage risks and ethical dilemmas.[214]

<u>Higher quality of service provision through strengthened quality assurance</u>

A high standard of health care is ensured through quality assurance activities and continuous quality improvement. The NHC is pleased to hear that the corrections health service recently initiated an incident reporting system and a national complaints monitoring system.

The new Health Quality and Safety Commission should be able to provide information on proven improvements and successful innovations and advise the corrections service on best practice, and may be able to facilitate relationships between prison health services and health sector providers.

> The NHC proposes that the quality assurance framework for prison primary health care services be strengthened with accreditation, monitoring and evaluation, standard clinical pathways, and independent audit.

Accreditation

An accreditation framework should be applied to prison health services. Cornerstone, run by the Royal New Zealand College of General Practitioners and used in over 800 primary health care practices throughout the country, could be used as is or could be adapted to enhance practice in prison clinics. Accreditation would help to improve the quality of the service and establish its credibility.

Monitoring and evaluation

Monitoring and evaluation processes are constantly evolving in the health sector. However, the NHC considers ongoing existing monitoring and evaluation in the prison health service is insufficient.

Monitoring and evaluation programmes need to:

- monitor clinical outcomes from particular services or programmes
- review the appropriateness and effectiveness of delivery of services to prisoners, including the effectiveness of health assessments
- develop feedback loops from monitoring, evaluation, and complaints processes and make changes accordingly
- develop a risk management framework.

Standard clinical pathways

The development of clinical pathways for the more common complex needs among patients (rather than a generic health care pathway) is a recognised method for improving the quality and consistency of services provided to patients and improving outcomes.

Independent audit

Providers of prison health services could have access to regular external audits in a similar manner to other health services.

Standardised, published audits using the *Prison Health Performance Indicator Guide* helped England and Wales lift performance in dozens of prisons during their transition from corrections-led to health-led service delivery.[215] Table 9.1 lists sample performance indicators from the *Prison Health Performance Indicator Guide*.

Table 9.1: Sample performance indicators for prison primary health care

Green	Amber	Red
Performance indicator: service user involvement The views of service users, their carers (including prison staff), and others are sought and taken into account in designing, planning, delivering, and improving health care services. Formal procedures are in place to ensure involvement, and such involvement is documented accordingly.	NO formal procedures are in place to ensure involvement, but arrangements are in place to address this.	NO formal procedures are in place to ensure involvement AND NO arrangements are in place to address this.
Performance indicator: primary mental health		

Green	Amber	Red
A primary mental health service triages referrals to secondary mental health services and offers a full range of primary mental health psychotherapeutic interventions to all suitable service users in partnership with general practitioner and primary health care, including access to child and adolescent mental health services and services to older adults where applicable.	A primary mental health service triages referrals to secondary mental health services but CANNOT PROVIDE a full range of primary mental health psychotherapeutic interventions to all suitable service users in partnership with general practitioner and primary health care, including access to child and adolescent mental health services and services to older adults where applicable.	Primary mental health care is provided ONLY by a general practitioner
Performance indicator: sexual health The sexual health of prisoners is supported by ALL of the following. Prisoners: • know how to access condoms in prisons • access the social and life skills modules on sex and relationship education or similar • have access to a genito-urinary medicine service in prison • have access to a chlamydia screening programme • have access to barrier protection and lubricants.	The sexual health of prisoners is supported by AT LEAST THREE of the five requirements listed.	The sexual health of prisoners is supported by TWO OR FEWER of the five requirements listed.

Source: Offender Health et al (2007).

Monitoring, planning, and information sharing

Reliable data collection is the lynchpin of health services analysis and planning. The corrections health service maintains an electronic record for each prisoner, but most of the data expected from primary health care agencies reporting in the community[216] is not recorded reliably and is not collated or analysed nationally. This information is, therefore, not available for service planning, funding bids, monitoring, performance improvement, or research.

The same health status and service measures expected within the primary health care system should be collected nationwide in the prison health system. For instance:

- health status information collated in each prison would serve as a baseline for comparison with other prison populations and the health of the population in the future
- health service measures, including service volumes, are essential for service planning and contracting and are another baseline for assessing change in the system
- these data would contribute to reviews of the health and disability status of the prison population at a national level (see section 8.2).

The NHC proposes the establishment of a comprehensive and integrated approach to health information. The approach will store and collate the health status and service data nationwide and, where appropriate, regionally and by prison for effective analysis and service planning. The approach must also support the transfer of medical records – with patient consent – from prison to community practitioners (see also section 9.3).

Recommendations

The NHC recommends that to improve the quality of prison primary health care and disability support services:

8 The agency responsible for primary health and disability support services in prisons:
- a advances the development of multidisciplinary primary health care teams
- b develops a continuing professional development programme for the prison health workforce
- c supports prison health staff to:
  - i establish clinical networks for all health professionals who work in prisons
  - ii join regional clinical networks with colleagues who work outside prisons
- d strengthens the quality assurance framework to closely align it with the frameworks used by other primary health care providers
- e ensures prison health services collect and analyse the same health status and service measures as primary health care providers in community settings.

9.2 Strengthen the identification, assessment, and treatment of health conditions and disabilities

Some health issues are managed well in the prison environment. The corrections health service responds successfully to acute injuries and puts treatment plans in place for prisoners with conditions requiring active monitoring and intervention. Forensic health services respond well when a serious mental illness is identified and capacity is available to treat the patient.

However, the NHC has identified a lack of *systematic* identification, assessment, and treatment for health and disability conditions in the prison health system. Problems are particularly notable in the areas of mental health (section 9.2.1), alcohol and other drug dependency and addiction (section 9.2.2), and oral health (section 9.2.4). The NHC recommends full health and disability assessments for each prisoner (section 9.2.5) and specific training for prison staff (section 9.2.6).

9.2.1 Mental health

The World Health Organization's Regional Office for Europe Mental Health Promotion in Prisons consensus statement asserts:[217]

> In the absence of positive counter-measures, deprivation of freedom is intrinsically bad for mental health, and that imprisonment has the potential to cause significant mental harm ...

> [A] concept of care, positive expectations and respect should permeate all prisons ... [T]he promotion of the mental wellbeing of prisoners and prison staff is vital in prisons.

Best practice in prison mental health care calls for adequate service provision for mental illness at every level of severity, from basic, brief response to forensic psychiatric treatment.[218] Improvements are needed in the identification, assessment, and capacity to treat mild, moderate, and severe mental health conditions among prisoners.

Identifying and assessing people with mental health needs

In trials of the 'New Zealand Prison Reception Mental Health Screen', about 30 percent of prisoners screened positive for a possible mental illness on their reception at prison. After assessment, about one-third of this group (10 percent of the total) required specialist forensic mental health treatment. Currently, only about half of these are receiving treatment. The *Framework for Forensic Mental Health Services* estimates an additional 13 percent of prisoners have a moderate to severe disorder,[219] potentially requiring forensic consultation and liaison services, and a further 8 percent have mild to moderate disorder.[220]

The Office of the Auditor-General estimates:[221]

> Prisoners are three times more likely to require access to specialist [mental health] services than the general population, [but] some prisoners with mental illness are undiagnosed and, therefore, go untreated.

The Department of Corrections has not yet put the screening tool in place. This reflects not only competing priorities within the corrections budget, but also the difficulty of attracting funding that must be sourced from different departmental budgets (ie, those of corrections and health). This problem is not unique to New Zealand. Western Australia's Inspector of Custodial Services writes, 'The way governance works, a divided bid is doomed ... A health initiative coming primarily from Justice is, in bureaucratic terms, an oddity'.[222]

A 'prison reception mental health screen' also remains to be developed for women.

NHC urges implementation of appropriate mental health referral decision tools for prisoners at reception in each of New Zealand's prisons.

Capacity to treat prisoners with mental health problems

In April 2010, the Auditor-General noted significant gaps in prison primary mental health services and was concerned that the Department of Corrections had not addressed many of the gaps previously identified in 2008.[223] This is of particular concern to the NHC in light of the disproportionate numbers of Māori in prison.

The Māori population has a higher prevalence and severity of mental disorder than other populations.[224] Māori with these needs are more likely to have them met by general practitioners than by other practitioners, but Māori also have lower access rates to general

practice services than Pākehā.[225] Therefore, Māori in prison are less likely than Pākehā prisoners to have received mental health treatment before arriving in prison.

When mild to moderate mental illness is identified, prisoners may have access to a doctor and medications, but counselling or therapeutic psychological treatment is not available.[226] Forensic psychiatrists and psychologists who visit prisons treat some patients with severe mental illness and can offer support to primary health care staff, but a large gap remains in responding to patients with mild to moderate illness.

Unmet need for both inpatient and in-prison forensic services is significant. At least 5 percent of the prison population (over 400 people) requires but cannot access forensic treatment in a given month.[227] Patients are shuffled between forensic units and local prisons as staff try to free beds for prisoners in more acute need. Some wait for long periods before a forensic bed becomes available and, while waiting, may deteriorate, damaging their chances of rehabilitation. Meanwhile others are moved back into prison, sometimes too early, due to a lack of residential treatment facilities.

Dedicated forensic inpatient psychiatric units are needed for women. Not only do female prisoners have different treatment needs from male prisoners, but they also tend to have histories as victims. It is inappropriate to place them in facilities without separation from male offenders.

Youth forensic services are also needed throughout the country.

Unmet need for forensic services is certain to grow. Prison numbers continue to increase. If the 'New Zealand Prison Reception Mental Health Screen' is implemented, it will uncover additional need for triage, assessment, and treatment.

<u>Capacity to treat prisoners with a personality disorder</u>

Neither the Department of Corrections nor the Ministry of Health takes responsibility for the response to personality disorders among prisoners, although the Ministry of Health 'accepts that personality issues are a priority for the health sector'.[228] Some people with personality disorders cannot be properly managed or treated in prison, so rarely receive adequate care. They may spend lengthy periods in at-risk or management (punishment) units, which can cause their condition to deteriorate.

The presence in prisons of individuals with untreated personality disorders and staff who are inadequately trained presents a daily threat to the health and wellbeing of other prisoners and staff. It also adds risk and cost to the operation of the prison system.

> In his five sentences he has never had a psychological assessment ... He has subsequently had a private psychiatric assessment, been diagnosed and treated with [cognitive behavioural therapy] and psychotherapy for a personality disorder which led to his intense anger episodes. For the past year he has not had any further anger outbursts, is reconciled with most of his family and he has not been involved in criminal activities for two years. My main point is that his ten years of crime, its impact on the victims and his family could have

> been avoided had he been properly assessed at the onset and received appropriate input from both the health and justice system.
>
> Mentor of a prisoner (in a letter)

The Ombudsman has expressed considerable impatience with this situation:[229]

> There are ongoing issues between the Department of Corrections and the Ministry of Health as to what mental illness is and what is a personality disorder. It is also apparent that Corrections staff are not trained to handle and/or treat this group and, moreover, do not have the appropriate facilities in which to treat them. On the other hand, although they may benefit from health facilities and treatment by health staff, the traditional health view is that these people do not come within their purview. With respect, this is unsatisfactory and it seems necessary to resolve philosophical differences at least, and perhaps matters of practice, in order to reach a solution – a solution which is in the best interests of both the offender and the community. This is not simply a management issue. It is an issue of humane and appropriate care.

The first Mason Report asserted, 'We believe that people with personality disorders will respond to psychiatric care'.[230]

The second Mason Report stated:[231]

> A serious difficulty in the field of personality disorder is that the concept of treatability is frequently equated with curability – which is totally inappropriate ... The medical profession should not collude with the public instinct to use this term as a device for rejection.

The NHC understands that the Department of Corrections has initiated a project to develop a shared services model for managing prisoners with multiple and complex needs producing challenging behaviour. This model may be a useful starting point, but the NHC believes the health sector should take responsibility for the treatment of personality disorder.

The NHC proposes that a team, led by Ministry of Health and including officials from the Department of Corrections, explores the full range of care options, including models developed overseas, for prisoners with personality disorder.

<u>Strengthen primary mental health care capacity in prisons</u>

Prisoners are entitled to the same level of mental health services, including continuity of treatment, as the general population.[232] The past decade has seen capacity and capability grow in community mental health services. Non-governmental organisations, iwi providers, and some services for parents have provided low or no-cost mental health care. More recently, the Primary Mental Health Initiatives have made mental health care available, through Primary Health Organisations, to thousands more New Zealanders at no charge.

The high prevalence of untreated mental illness, the exacerbating conditions of prison, and prisoners' poor access to traditional support such as family and whānau, friends, and physical activity mean primary mental health capacity should be strengthened for this population as

well. This capacity includes the identification of mental illness, ability to respond with brief interventions, appropriate referral, and culturally appropriate practice.

Corrections psychologists in prison may struggle to develop sufficient trust with patients for a successful therapeutic relationship, given their relationship with the criminal justice system.

The NHC suggests building capacity by developing the mental health treatment capability of the prison primary health care team (and increasing their responsibility accordingly) or by bringing in community mental health services. Prison walls should not be a barrier to adequate mental health treatment.

Strengthen capacity to respond to serious mental illness in prisons

To respond to people with serious mental illness, the capacity of forensic services needs to increase to meet the demand.

The founding document of the Regional Forensic Mental Health Service includes the following principles.[233]

- Service users' needs for mental health care should govern their access to services.
- Service users should be accommodated in facilities that match their need.
- Service users should be treated in the least restrictive environment that their circumstances allow.
- Services should be client-focused, enhancing wellbeing, and preserving dignity.
- Services should be culturally appropriate, treating the whole person and involving whānau and families.
- The approach to care should be holistic, integrated, open-minded, and non-judgemental.

The NHC believes the only way New Zealand can live up to these principles is to add capacity in appropriate areas and levels within the national forensic services system. This increase in capacity would ensure each patient receives the care most appropriate to their needs.

Improve transition pathways

Capacity for community mental health treatment also needs to continue to be strengthened to relieve pressure on forensic units. New Zealand lacks sufficient step-down beds and services for people to transition safely out of forensic care. Depending on the institution's response, this can unravel therapeutic progress (increasing the investment required in the long term) or obstruct access to care for those who are waiting. Care providers we met observed that Māori are most affected by this lack of 'step-down' support. Making more step-down services available would be more cost-effective for the health system and would mean services would be more appropriate to needs.

There is a long-standing concern in the psychiatric community that:[234]

> without well-funded and resourced community care, the mentally ill can find their behaviour criminalised, and themselves reinstitutionalised in prisons or in [forensic mental health] hospitals.

This concern can tend to undermine calls for expanding forensic hospital capacity. The NHC shares the concern, but sees a need for expansion on both fronts – institutional- and community-based.

Stigma attached to the forensic 'label' can make it difficult for clients trying to access appropriate services.[235] Clarity is required about the responsibilities of the forensic psychiatric units, Adult Mental Health Services, and the Department of Corrections. Capacity among Adult Mental Health Services is variable around the country and needs to be developed in some regions.[236] Mutually agreed pathways from forensic services to Adult Mental Health Services are needed. This could be resolved with the development of clear transition pathways and a protocol for resolving concerns among these agencies.

Alcohol and other drugs

Identifying and assessing addiction

Nationwide, alcohol and other drug screening, assessment, and treatment for people in the criminal justice system is highly inconsistent. There is no single agency responsible, no single repository for information, and no formal arrest screening and referral scheme – although a few DHBs provide such services. However, these services are particularly vulnerable to local funding pressures (eg, in Canterbury, assessments are no longer available from the DHB to prisoners up for parole more than six months before their release date). Pilot projects placing alcohol and other drug and mental health professionals into courts to advise judges have shown promise, but they exist in only a few of the country's 63 courtrooms. Funding streams and reporting mechanisms vary, making these projects vulnerable to change.

Not enough alcohol and other drug assessments are being conducted, and recent cuts to legal aid funding mean many assessments currently available may no longer be accessible to many prisoners. As a result, people are continuing their sentences with unidentified or poorly assessed addiction.[237] The problem is likely to follow them out of prison – in many countries, drug overdoses have been found to be the leading cause of mortality for recently released prisoners.[238]

In addition to being poor health practice, the lack of assessments also undermines community safety. It has been estimated that more than 2,000 inmates with substance abuse problems are released from prison each year without an alcohol and other drug assessment.[239] The New Zealand Parole Board has emphasised that without alcohol and other drug assessments, it cannot accurately assess the risk prisoners pose to community safety, so cannot determine parole status eligibility for those before them with dependence and addiction issues. The Parole Board is often in the impossible position of needing to know whether an assessment is required in advance of meeting the prisoner.

Barriers to treating addiction

Prisoners do not have access to alcohol and other drug treatment options that are equivalent to those available to members of the wider community. There are several reasons for this.

Department of Corrections alcohol and other drug services

Policies of the Department of Corrections can act as barriers to treatment for addictions.

- Participation in a drug treatment unit is limited to those for whom alcohol or other drug misuse is seen as a factor in their offending and who will serve long enough terms to complete the six-month programme.[240]
- If a prisoner tests positive for drug use, they are given Identified Drug User status, even when they have an acknowledged addiction.[241] The prisoner may become ineligible for addiction treatment for up to a year. A disciplinary charge may also be laid.[242]
- With a few exceptions, methadone maintenance treatment is not available to prisoners who were not already on a prescribed methadone regime when they entered prison.[243]

In 2007, officials estimated that drug treatment units within prisons reach about 3 percent of prisoners for whom substance addiction was a factor in their offending.[244] The establishment of new drug treatment units in 2010 is a positive step. However, Drug Treatment Units will still reach only a small proportion of prisoners who need this treatment, and the prison population continues to grow.

The NHC is encouraged by the development of three-month, intensive drug treatment programmes for those on shorter sentences, but notes that those with less than a four-month sentence (ie, most prisoners)[245] will still remain ineligible.[246]

District Health Board alcohol and other drug services

District Health Boards are responsible for specialist alcohol and other drug services for those who are not in a drug treatment unit in prison. Few DHBs provide these services in prisons.[247] An exception has been the Waitemata DHB Community Alcohol and Drug Service Offender Project, which includes group sessions in Auckland prisons. This pilot project has shown much promise.[248] One participant said, 'If there is any time to get someone on this whole alcohol and other drug journey, that [inside prison] is the time'. However, for this initiative to succeed, it requires reliable funding for the future.

These barriers to services within prison mean some people in the community 'jump the queue' for alcohol and other drug services because more qualified patients are behind bars and DHB services do not come in to treat them. The NHC has serious concerns that this effectively widens health inequalities and perpetuates a spiral of poor health and addiction among those most at risk.

Investment in community treatment is essential to provide for the needs of those low-level offenders who are excluded from in-prison treatment, yet continue to cycle in and out of prison as long as their alcohol and other drug problems remain unaddressed.[249]

Withdrawal

The corrections health service reports that it stages a controlled withdrawal from addictive drugs, but the NHC heard repeatedly that some people are subjected to 'cold turkey' detoxification from substances such as benzodiazepines and other psychiatric medications.[250] This tormenting process sometimes takes place within an at-risk unit, a clinically inappropriate venue.

The NHC is concerned about these accounts. A staged withdrawal, initiation of methadone maintenance, or other clinically indicated response should be undertaken. A call to the prescribing physician or urine testing can resolve any doubts about the nature of the drug (as is done in other countries). There is never a good reason for forcing unaided withdrawal on an incarcerated person, and it could be argued that doing so violates the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment to which New Zealand is a signatory.

The NHC endorses the following statement in relation to unaided withdrawal and in relation to all aspects of prison health care:[251]

> The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment is aware that in periods of economic difficulties ... sacrifices have to be made, including in penitentiary establishments. However, regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment. Compliance with this duty by public authorities is all the more important when it is a question of care required to treat life threatening diseases.

Co-existing conditions

Co-existing mental illness and substance abuse and addiction problems are common among prisoners and complicate service provision. Providers of mental health and alcohol and other drug services traditionally have different philosophies and use different language to define their core business processes. Community alcohol and other drug providers have sometimes been reluctant to take on clients with mental health problems and referrals from courts or probation.[252] Some mental health providers are reluctant to see people with addictions. Individuals needing both services may have to access services one at a time, or wait long periods during an extremely vulnerable phase of their illness or recovery. This disjointed service provision makes access difficult, limits the chance of successful recovery, wastes the time of health professionals and other workers, and wastes public funds.

The Ministry of Health addresses these difficulties in the Co-Existing Problems Project. This project establishes a nationwide goal: both mental health and alcohol and other drug services are to be 'co-existing capable' (ie, able to address initial screening assessment and brief interventions for people with both conditions).

The Ministry of Health has supported the Drug and Alcohol Practitioner's Association of Aotearoa New Zealand to expand competencies to incorporate co-existing disorders including problem gambling and tobacco cessation. The Ministry's Let's Get Real initiative also encourages mental health and alcohol and other drug services to work more closely together, with a particular focus on values, attitudes, and beliefs where service philosophy and stigmatisation may prevail between these services.

There are training opportunities for prison health staff through Matua Raki, the Ministry of Health funded alcohol and other drug workforce development programme. Any alcohol and other drug relevant training provided through Matua Raki includes working with co-existing problems.

The future prison mental health and alcohol and other drug workforces must be skilled in both treatment modes or have far closer links with one another. These links need continued strengthening, and providers need continued support for training.

9.2.3 Increase focus on minimising harm and reducing demand

Comprehensive responses to alcohol and other drug abuse involve a combination of approaches:[253] reducing supply, reducing demand, and minimising harm caused by alcohol and other drug abuse.[254] The Department of Corrections searches visitors to prisons, uses surveillance techniques, and uses drug dogs to limit alcohol and other drugs in prison (reducing supply). The department provides methadone maintenance treatment for opioid-dependent prisoners to minimise harm. It also administers screening and provides drug rehabilitation programmes to address criminogenic[255] (not health) needs.

<u>More emphasis on reducing demand and harm</u>

More emphasis can be placed on both demand reduction and harm minimisation in prisons. The United Nations Office on Drugs and Crime has suggested there has been an imbalance in resourcing and policy priorities between supply control measures and measures aimed at reducing demand by treating drug dependency and addiction. Experts in prisoner health agree:[256]

> Undue dependence on supply reduction measures, without attention paid to harm minimisation measures, exposes prisoners, and therefore the general community, to unnecessary expense and health risk.

This balance should be redressed to increase resources for prevention, treatment, and research to better understand what makes people vulnerable to addiction.

People with addictions in the community have free access to harm-minimisation programmes such as needle exchange programmes, and to preventive and health education measures to limit harm and disease transmission. At the same time, risky activities such as illicit drug use, assault, tattooing, and unsafe sexual activity are not uncommon in prisons. An equivalence of care based on needs approach would mean best practice harm minimisation throughout the prison system.

Measures aimed at reducing the adverse health and social consequences of drug use are also necessary.[257]

> What is needed is a comprehensive package of measures to reduce vulnerability, treat the drug illness, and prevent the spread of diseases that precede or accompany drug use, like HIV and hepatitis.

New government initiatives

Positive government initiatives related to alcohol and other drug dependence and addiction include:

- new treatment for methamphetamine-dependent individuals
- regulatory and legislative reform on alcoholism and other drug addiction
- improving access to addiction treatment services to the justice sector[258]
- exploring problem gambling in prisons
- diversion of 300 young offenders into community-based alcohol and other drug treatment.[259]

National alcohol and other drug action plan for assessment and treatment

The initiatives listed above are positive, and are likely to benefit many with addictions in the criminal justice system. However, the need remains to draw together disparate procedures into a coherent, efficient system with clear purpose.

> The NHC calls for a coordinated national action plan for alcohol and other drug screening, assessment, service provision, and funding that takes into account both criminogenic and clinical needs.

The primary objective of a coordinated national action plan should be to improve health outcomes. Within the plan, offenders should be a priority clientele. It is also important that adequate community drug and alcohol services are available to people with addiction problems who are not offenders; otherwise, perverse incentives could arise for people to offend in order to access treatment services. This plan will complement the National Drug Policy in government efforts to improve assessment, advice, and treatment services.

The NHC suggests the National Alcohol and Other Drug Action Plan contains:

- nationally consistent standards for eligibility and quality of assessment
- nationally consistent referral pathways
- nationally consistent standards for eligibility and quality of treatment
- a monitoring and evaluation framework.

To address in-prison alcohol and other drug use, the NHC suggests the national action plan:

- acknowledges the reality of drug use in prison
- recognises the influence of factors such as enforced inactivity, the absence of clean needles, and oral health policy on drug use and associated health risks
- proposes ways to mitigate these factors
- acknowledges the factors influencing addiction for women and the significant impact addiction has on their families and their likelihood of offending
- expands the numbers of prisoners with addictions who can access treatment by:
  - exploring options for admitting patients to drug treatment units or community residential therapeutic communities even when their condition is not seen as criminogenic
  - eliminating the rule that identified drug user status prohibits an addicted drug user from treatment
  - initiating (not just continuing) the methadone maintenance programme in prisons for patients for whom it is clinically indicated
  - exploring ways of safely introducing the same pharmacotherapies available in the community
  - establishing treatment pathways that follow patients through release into the community
  - embedding prevention and health promotion including drug education in all prisons
  - implementing evidence-based harm minimisation programmes
  - implementing measures to reduce the risk of drug overdose as prisoners exit the prison.

9.2.4 Oral health

The World Health Organization considers oral health an important requirement for quality of life. A dental examination can detect early signs of nutritional deficiencies and immune disorders.[260] Good dental health services can reduce premature mortality. Poor oral hygiene and periodontal disease are associated with cardiovascular disease.[261] In addition, drug use can have a devastating effect on the health of teeth and gums, which a person may come to realise only once they are in prison and no longer using drugs. Conversely, unrelieved tooth pain can drive people to illicit drug use.

Current arrangements

New Zealand prisons have no coherent national vision for oral health services. The Department of Corrections' national procedures guiding prisoner dental services are brief and focus on procedural and minimum requirements for services: all prisoners should receive prompt pain relief, and prisoners detained for one year or more, and who have shown 'previous dental responsibility',[262] may receive a limited set of treatments.

Each prison health service contracts dentists on a sessional basis. Prison health services cannot always obtain enough dental clinic hours for everyone needing an appointment. Many who may be eligible for treatment do not get to the dentist at all. One prisoner reported to the NHC:[263]

> Last year I filled in a form in July. I didn't get seen till just before Christmas. But by then I'd already pulled it out myself. They'd given me Panadol, cloves, no good. It was too painful. I couldn't eat I was in so much pain. I was losing weight. It's not uncommon. I've pulled three out myself so far.
>
> Timaiti, Māori man, 40–50 years

Others receive only rudimentary pain relief or extraction. Research participants believed the 'previous dental responsibility' requirement was to blame for the high rate of extractions when a filling would have been more appropriate.[264]

> They'll just say we'll just rip it out but nothing's wrong with it, it just needs to be filled in.
>
> Tipene, Māori man, 18–25 years

The Office of the Ombudsmen in 2005 said in regard to dental care:[265]

> We did not receive one good report from prisoners. ... It seems to us regrettable that a person who cannot help himself or herself may suffer needless dental deterioration while in the care of the State.

The Office of the Ombudsmen concluded that neither the corrections system nor the health system was providing the standard of dental care that should be expected and recommended the Department of Corrections conduct a full review of the adequacy of dental services.

Review of prison oral health policy and practice

The NHC is gravely concerned about the state of oral health services in New Zealand prisons.

The 'previous dental responsibility' criterion precludes access to clinically appropriate treatment for people from low socioeconomic backgrounds or with a poor understanding of oral health care. The NHC supports access to dental care to stabilise a patient's oral health or to stabilise the patient's general health, regardless of sentence length or 'previous dental responsibility'. Sometimes it will be necessary to enhance oral health before general health can be stabilised. These are clinical decisions a dentist should make for the benefit of the patient's health, not to answer institutional requirements.

Even a short period of incarceration is an opportunity to make a positive impact on the oral health of people in a high-needs group. Meeting the basic oral health needs of prisoners will help to address health inequalities among the larger population. At the same time, the NHC is aware that the poor oral health status of many prisoners largely reflects the limited publicly funded adult services provided in New Zealand. Therefore, the NHC sees the provision of oral health services as a whole as an issue that deserves attention from policy makers. Until then, oral health is an area in which a standard of equivalence with current services to the community needs to be surpassed.

The NHC urges a review of oral health services in prisons. The review should be developed in collaboration with dental clinicians.

The objectives of a review of oral health services should include:

- a national vision and strategy for prison oral health services with a strong health outcomes focus
- consistent planning, management, and administrative procedures
- new eligibility criteria so prisoners receive the dental care they require, regardless of perceptions of 'dental responsibility' or length of sentence.

The NHC suggests including an analysis of the school dental service model in the review, as aspects of that model may be usefully adapted for prison oral health care.

Oral health – self-care in prisons

As wards of the state, prisoners should be provided with the basic tools to look after their oral health. Simple measures including providing education and dental floss are cost-effective ways of improving prisoners' future oral health status (see the example in Box 9.2).

The NHC understands that dental floss and mouthwash are not made available to prisoners for security reasons, but urges some discretion in the implementation of this policy.

Box 9.2: Time for Your Teeth resource package, United Kingdom

Time for Your Teeth is a resource package developed in the United Kingdom that has been distributed to all 130 prisons in England and Wales. The package includes quizzes, posters, and a short video. In one trial, it improved knowledge about oral health by 35 percent.

Twelve prisoner volunteers discuss their dental health issues in the video to help other prisoners. The resource thoroughly and clearly demonstrates how to clean teeth and dentures and discusses the effects of drug and methadone use on oral health.

Time for your Teeth earned a World Health Organization Health in Prisons Project Best Practice Award in 2005, and the Centre for Public Innovation honoured the film-maker with an award.[266]

The NHC supports all prisoners receiving sufficient basic hygiene aids (toothbrushes, toothpaste, interdental floss, brush or picks) as part of 'standard issue' and ongoing oral health education and promotion programmes in all prisons.

9.2.5 Comprehensive assessment is necessary

Comprehensive assessment means appropriate clinical intervention at the earliest opportunity, in-prison assessments, effective assessment tools, and training staff to identify and refer patients appropriately.

'Earliest opportunity' contact

The earlier a therapeutic intervention takes place, the more clinically effective and cost-effective it is likely to be.

Watch-house Nurses is an example of good practice in early contact. It is a joint initiative of the New Zealand Police and the Ministry of Health, placing mental health and alcohol and other drug nurses in police watch-houses in Counties Manukau and Christchurch from the middle of 2008. An interim evaluation has confirmed the programme is providing more appropriate referrals to community mental health and alcohol and other drug services, forensic services, general practitioners, and non-governmental organisation treatment services; assisting the New Zealand Police; and improving relationships between the New Zealand Police and DHBs.[267]

The NHC supports the extension and expansion of the Watch-house Nurses programme, if the upcoming impact evaluation shows continued positive results.

In-prison assessments

Everyone who enters prison needs a health and disability assessment followed by appropriate referral and specialist assessment. Prisoner patients should be assessed for their needs, not in relation to the facilities or services available.

A full assessment would enable a clear plan to be developed for treatment and support services. Assessment or referral decision tools should cover:

- mental health conditions
- addictions or dependence
- chronic physical conditions
- infectious diseases
- vaccination status
- oral health needs
- visual and hearing acuity
- intellectual disability
- learning disabilities.

The NHC recommends patients are referred for the appropriate treatment, support, or rehabilitation service as soon as a problem is identified.

In 2006, the Department of Corrections developed a health and disability assessment tool based on the Māori health model Whare Tapa Whā. The NHC is pleased the assessment is set for implementation in all prisons in August 2010.

Effective tools

The NHC considers that a good health and disability assessment tool is dynamic to incorporate new insights, medical knowledge, international best practice, local expertise, and cultural relevance.

> The NHC supports ongoing expert clinical oversight, ongoing improvement, monitoring, and evaluation of all health and disability referral decision tools and assessments for prisoners.[268]

Disabilities

The NHC has identified conditions requiring improved identification, assessment, and treatment. This report focuses on mental health, alcohol and other drug dependence and addiction, and oral health. But the needs of prisoners with disabilities also deserve a mention, particularly in relation to strengthened identification, assessment, and treatment processes.

Head injury and intellectual disabilities

Head injury is called a 'silent epidemic' because it is under-reported, not well diagnosed, and poorly managed. Many symptoms may make a brain injured person susceptible to criminal activity.[269] These are the same traits that can make a person a target inside prison. Health staff and prison officers may not be aware of the injury or the ways others can victimise these prisoners.

There is no systematic in-prison identification of neurological damage or intellectual disability. A sizeable group of prisoners is not covered by the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2004, which allows the court to commit a defendant to a secure therapeutic residence outside prison. This group includes people who have not yet been identified, who have an IQ just above 70,[270] who sustained a head injury after the age of 18, or who feel neither shame nor remorse for harm they have caused, even if this is a result of their disability.[271]

Ministry of Health-funded Disability Support Services will not cover support needs if the person was impaired when they committed the crime. If a person with acquired brain injury is not eligible for accident compensation or under mental health statutes (due to a co-existing psychiatric condition), there are no provisions for diversion, treatment, or support.[272] There are likely to be many people in prison under these circumstances, as well as people with neurological disease, dementia (particularly alcohol-induced dementia), or who suffer from a fetal alcohol spectrum disorder. The first step to identifying appropriate responses is the identification and assessment of these prisoners and their health and disability needs.

Sensory disabilities

The absence of support for genuine vision correction for prisoners was the most frequent concern raised by prisoner advocates. There is limited eligibility for glasses or other visual assistance (eg, magnifiers or screenreaders) through Disability Support Services and a part-

charge would be likely to apply. These expenses are often beyond the prisoner's means, or cause hardship to the prisoner's family.[273] Reading glasses are in demand by prisoners, but are not supplied by the Department of Corrections.

A prisoner with hearing loss may be eligible for free hearing therapy and adaptive living training, but most hearing therapists and advocates we contacted expressed concern that referrals are not coming from prisons and that many prison staff are unaware of Deaf culture and of the existence of services, support agencies, and interpreters. The NHC was often told that prisoners with hearing disabilities can be mistaken for 'troublemakers' by prison officers and subject to punishment for not hearing and acting on instructions.

There are detrimental effects from boredom and frustration, vulnerability, and isolation for prisoners with visual or aural impairments. Consequences such as bullying, fights, depression, anxiety, and drug-taking fall on all staff and residents of the prison.

Prison health staff have a low level of awareness about and ability to access disability services beyond the basic supports provided by the prison system; this is sometimes an obstacle. The NHC gained the impression that obvious, visible impairments were attended to but others were overlooked or held up in paperwork for so long that the prisoner was transferred or released before action was taken.[274] There is no evidence that hearing is tested after head trauma in prison.

Imprisonment should not mean that a prisoner's health is neglected or allowed to deteriorate. Prisoners should have genuine access to the same range and standard of disability support services as the general population. This means thorough assessment, access to a Needs Assessment and Service Co-ordinator, a new accident compensation claim, or any other service available to the public. The health and corrections sectors should also consider a level of support to prisoners that, at the least, maintains any disability aids they had when they entered prison.

9.2.6 Training staff to identify potential health and disability issues

Prison officers, along with health staff and others in regular contact with prisoners, play an important role in the early identification of health conditions and hidden disabilities. Appropriately prepared staff will be able to refer patients to the health team for diagnosis or treatment.

The NHC recommends all prison staff are trained to identify signs of health conditions and disabilities common among prisoners, including:

- mental illness, including personality disorder
- suicidal ideation
- alcohol, other drug, or gambling addiction or dependence
- intellectual disability
- neurological damage or brain injury
- brain injury or neurological disease

- disability needs, including visual and hearing impairments.

9.2.7 Greater reliance on community treatment options

Not every prisoner consents to treatment, but for some who would consent, no treatment is available.

An important part of a therapeutic approach (discussed in section 7.4) is access to community treatment and residential facilities. Greater investment in, and use of, these facilities is critical for improving health and reducing reoffending for some people with serious mental health conditions, alcohol and other drug addiction, and intellectual disabilities or brain damage.

For many, community care is a more appropriate environment than prison. Therapeutic community environments need not create risks to public safety, but they do provide more effective rehabilitation, allow more clinically appropriate treatment, improve prospects for recovering from addiction, and reduce the risk of vulnerable prisoners being assaulted or 'stood over'. For the community, better treatment of this group of prisoners will help reduce health inequalities and improve family and community health and social outcomes.

Greater use of community treatment options may require expanded sentencing options or expanded eligibility for community facilities. Some ideas worth exploring are enabling people who are not eligible for the in-prison drug treatment unit to transfer directly to community facilities or to participate in shorter in-prison addiction treatment programmes that connect directly with community treatment or 'aftercare' on release.

<u>Residential therapeutic communities</u>

Residential facilities are particularly needed to treat some forms of mental illness and addictions. More and similar services are also needed for people with a personality disorder, a brain injury, or an intellectual disability.

Personality disorder

Research has suggested almost 60 percent of New Zealand prisoners have a personality disorder.[275] The Department of Corrections and Ministry of Health both acknowledge the presence of people with serious personality disorder in prison who cannot currently be effectively treated or managed there. Some of these prisoners, notably women, pose more risk to themselves than to others. Hospital inpatient treatment is also not recommended, as this can worsen symptoms.[276] Less severe personality disorder has been treated successfully with cognitive-behavioural therapy, psychodynamic approaches, psychotherapy, and drug treatments.[277] Holland, Canada, and the United Kingdom also have models for the treatment of personality disorder.[278]

Secure prison therapeutic facilities may also be an option for some offenders. For instance, units such as Te Piriti and Kia Marama are designed to treat sex offenders. An example of a therapeutic community model for personality disorder is summarised in Box 9.3.[279]

Box 9.3: Therapeutic community model for personality disorder, England

Her Majesty's Prison Grendon is a specialist centre for the treatment of people with personality disorder, particularly when it gives rise to serious offending. Five therapeutic communities within the prison offer intensive group psychotherapy and social therapy.

The emphasis is on multidisciplinary teams with each team consisting of a forensic psychologist, prison officers, a probation officer, and a psychotherapist. By exploring the past and present, clients begin to make sense of the cycle of abuse. By forming reparative relationships with staff over a period of years, clients can turn away from violence.

The NHC suggests consideration be given to establishing residential therapeutic communities within and outside of prison for people with personality disorder.

Head injury and intellectual impairment

Sixty-four percent of male and 55 percent of female prisoners have experienced at least one head injury. Some of these injuries have lasting effects that make it hard for these prisoners to adapt to life in prison, and beyond.

The NHC suggests possibilities be explored for new therapeutic facilities for people with debilitating brain injuries. The NHC has also concluded that there is a gap in service provision to meet the support needs of offenders whose ability to function is limited by an intellectual impairment, but who do not meet the provisions of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2004. This might include individuals who sustained a head injury after the age of 18 or whose IQ is just above the criteria for accessing current facilities.

<u>Less-intensive community-based treatment and rehabilitation</u>

The need for more transition and step-down facilities and services goes hand in hand with the residential treatment options discussed above. Boosting transition service capacity and adding capacity and capability where it is needed in community mental health services and community alcohol and drug services will reduce the pressure on more intensive and expensive facilities. The provision of these services at a regional level will enable recipients to move to the most appropriate level of care, rehabilitation, and security and move as close to home or family support as possible.

The NHC encourages the justice and health sectors to explore options for expanding community treatment, to improve outcomes for offenders with significant health and disability conditions.

Recommendations

The NHC recommends that to improve the identification, assessment, and treatment of health conditions and disability support needs of prisoners:

9 The agency with responsibility for primary health and disability support services in prisons:
   a conducts health and disability assessments for each prisoner when they enter prison
   b works with other funders and providers to ensure service delivery is adequate to meet the needs identified in the prison entry, and subsequent, assessments
   c provides appropriate training to prison officers, health staff and those in regular contact with prisoners, to enable them to identify health conditions and impairments that are prevalent among prisoners.

9.3 Ensure seamless continuity of care

9.3.1 Continuity of care is critical for improved reintegration and rehabilitation outcomes

Recognising that a focus on security and containment makes it difficult to encourage rehabilitation and reintegration, the Department of Corrections has removed its reintegration team from its Prison Services group. A new Rehabilitation and Reintegration Services group, combining offender management, employment, psychological services, and reintegration functions, is to be established. Spending on rehabilitation has also been doubled in the most recent budget.[280]

The NHC recognises the importance of strong institutional support in promoting positive rehabilitation outcomes. It is hoped that the restructuring of the service will elevate health concerns for prisoners in the rehabilitation and reintegration process. Health and wellbeing are integral to successful reintegration. Prison health staff should play a stronger role in the reintegration process.

Successful reintegration practice builds on the strengths of prisoners and their families and whānau, and provides assistance in overcoming vulnerabilities such as addiction or poor health.[281] This reduces the likelihood of offending.

Improving the success of reintegration requires change in key areas relating to continuity of care, including:

- easier access to the offenders with whom health and support workers are working
- continuity in prisoner contact with support workers *before and after* release
- collaboration and information sharing among health providers before the prisoner's release
- strong support for, and communication between, prison health and reintegration teams to ensure seamless continuity of care
- enhanced resources, in particular for housing support, employment support, community alcohol and other drug treatment, and reduced primary health care costs

- support for non-governmental organisations and Whānau Ora practitioners to guide the former offender through the maze of health, social, and private institutions required to start a new life
- co-ordination among agencies to improve released prisoners' access to multiple services when they are needed.

9.3.2 What is needed for continuity of care in prisons

Continuity of care in prisons requires health and disability assessments on the prisoner's entry to prison, continuity of treatment among prisons, continuity of medication, and timely transfers of health information.

Health and disability assessments on entry

Entry to prison presents an opportunity for a comprehensive health assessment (see the discussion in section 9.2.1).

Minimising inter-prison transfer

Inter-prison transfers are commonplace. Transfers can damage relationships if people move far from their family and can disrupt therapeutic relationships. Workshop participants told the NHC:

> Transfers make 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.

A 'hold' can be placed on a transfer when there are health concerns, but the NHC has heard repeated accounts from providers and prisoners of transfers taking place in spite of the concerns of a health professional.

The health needs of prisoners should be given significant weight in decisions about inter-prison transfer. If any health professional has concerns about the implications of overriding the 'hold' on the prisoner, a discussion with the prison manager should be required before the prisoner can be moved.

The NHC understands that electronic records transfer is now possible among all prison clinics. When a move is required, medical records and treatment plans need to be transferred direct to the new prison health team.

Continuity of medication and support

Medication schedules are not always maintained throughout the transition in to and out of prison. This can have a serious impact on a person's mental and physical health and, in the case of unaided withdrawal, can be fatal.

NHC-commissioned research found it was common for people to have their medications temporarily or permanently suspended on entering prison while their medical and prescription

history was verified. One inmate chewed part of his tongue off during a week-long wait for resumption of his psychiatric medication.[282] It was also common for those on drugs with specific street values to have their drugs permanently discontinued on arrival in prison.[283]

Exiting prisoners also face far higher risk of death from overdose of illicit drugs. An innovative programme in Scotland is designed to change that (see Box 9.4).

Box 9.4: Reducing drug deaths after release, Scotland

The prison system in Scotland recognised an alarming level of post-release deaths – roughly the same as the number of natural deaths in prison. The peak risk time is within the first two weeks of release.

The prison system put in place emergency kits for exiting prisoners. Prisoners with known drug addictions are given Naloxone, an overdose antidote to opiate overdose, and taught how to use it. Those who entered prison with 'works' are given clean works as they leave. They are also given resuscitation training.

The effectiveness of this approach is not yet known, but it represents a serious attempt to address post-release overdose deaths.[284]

In the effort to prevent post-release deaths, WHO Europe emphasises the importance of interagency coordination in providing continuity of care:[285]

> Interagency partnerships between corrections-based and external service providers are essential to the establishment of effective end-to-end services for prisoners. When correctly managed, the processes of government and non-government agencies and community supports can be integrated and coordinated, with appropriate referral systems ... Social support structures are of significant importance to prisoners and provide a post-release psychological buffer. This is of particular relevance to high-risk persons.

<u>Timely transfers of health information</u>

Continuity of care requires the smooth transfer of health information between health service providers. The Department of Corrections has improved prison procedures for transferring records between prisons. However, obstacles remain to electronic records transfer from community provider to prison clinics and vice versa.

More integrated information technology is a priority in the health system. If prison and community health services were linked and information transfer improved, it would be easier for health providers to serve prisoners after their release, supporting their reintegration.

The NHC believes the problems remaining can be overcome without compromising patient confidentiality or the security of the corrections data system. Priority should be given to building the systems and relationships needed to create seamless data transfer to enable continuity of care.

Better information sharing, with patient consent, among the courts, forensic units, the Department of Corrections, hospitals, primary health organisations, and other health providers would streamline processes and reduce the costs and frustration arising from repeated interviews and assessments.

Access to primary health care in the community

The NHC was told that good work done by corrections health 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. Access to community primary health care is essential to maintain any health gains made in prison or to address neglected health needs.

NHC-commissioned research echoes other research, showing that the cost of primary health care can be a barrier to access for households on low incomes.[286] Many released prisoners and family members reported that the general practice fee (up to $60) was unaffordable. They often put off attending (or swore off returning) after having to choose between going to the doctor and paying for food or accommodation.[287]

Many released prisoners report being unable to enrol in practices whose 'books' are closed. This should be of great concern to policy makers interested in improving health outcomes and reducing health inequalities.

9.3.3 What good continuity of care would look like

NHC workshop attendees said many prisoners are not experienced participants in the health care system, so may accept low levels of care. Prison health staff are responsible for health assessment, planning, and follow-through. Therefore, they must be assertive in delivering care and information delivery.

A key principle for continuity of care is *active referral* from each stage of the health care pathway to the next. The NHC believes the responsibility for active referral rests with the primary health care team in prison. For instance, the team could arrange continuing alcohol or other drug treatment on the prisoner's release, make a referral direct to a mental health provider, or request a disability needs assessment from a provider well in advance of the prisoner's release. A Whānau Ora practitioner in their service coordination and navigation role could be of assistance for many prisoners.

For continuity of care, prison primary health care teams should:

- contact the prisoner's family general practitioner, where possible, to obtain his or her medical history
- start to plan for the prisoner's release needs at the first health assessment, with family or whānau participation if possible
- routinely reassess the plan, with the patient, throughout their sentence
- actively encourage prisoners to enrol with national screening programmes

- ensure uninterrupted medication regimes on entry to prison, between prisons, and on release[288]
- take a central role in the reintegration process, in collaboration with the reintegration team and a Whānau Ora practitioner, where appropriate, by ensuring:
  - every prisoner has a reintegration plan with a health component
  - other reintegration needs (eg, housing, education, employment and , relations with family and community) will be met in a way that coincides with health needs
- initiate and complete the transfer of care and medical records (including identifying a general practice in consultation with the prisoner, contacting the practice to enrol the patient, transferring medical records, and setting up an initial appointment), and if prisoners do not identify a destination, they should be handed their medical records on release[289]
- ensure the patient can afford the fee (see Box 9.5 for an innovative programme)
- supply all leaving prisoners with contact information and instructions for accessing primary health care, emergency contact information, and information to help prevent an accidental drug overdose
- follow up with released prisoners who have health or disability support needs shortly after their release from prison, in collaboration with a Whānau Ora practitioner, where appropriate.[290]

Box 9.5: Funding for comprehensive health assessment to access primary health care, West Coast, New Zealand

Since 2006, the West Coast Primary Health Organisation has been offering funding for comprehensive health assessment at a general practice after prisoners are released. The funding is in the form of vouchers issued by community probation officers to recently released prisoners on the West Coast. The Primary Health Organisation will fund up to three follow-up consultations.

'These are really high needs people who would normally not access health services even with low cost service', says the clinical manager. 'The benefits are high. It doesn't put too much stress on the practices but is very valuable to the patients.' Practices will provide a full body system assessment including cardiovascular risk assessment and mental health, diabetes and cervical screens if relevant. The programme provides steady referrals and is seen as successful and efficient. 'On the Coast we don't want any barriers to access to health care.'[291]

The NHC heard the following story from a community provider. It illustrates what is possible when services are well co-ordinated:[292]

> Aroha is the reintegration worker at the prison. She is brilliant. She set up a meeting of the people who were going to be involved in this woman's release. I was there, mental health and [alcohol and other drug services] were there, a woman who's been mentoring her in prison was there, and the inmate was there. This woman was very, very frightened of getting out; outside is terrifying. We were able to reassure her that we would have this package of care for her. She had been released two years ago to another city, where she said Mental Health [Services] let her down, and so on. So this time we put this package of care in, it's working brilliantly so far, she went into a Salvation Army supported

> accommodation house in town ... That's for three months, and I think it should be longer, but anyway, she's housed, and she's regularly visited by mental health, and I visit her. She's also got links to [the Prisoners' Aid and Rehabilitation Society]. So she's feeling pretty good, she's upbeat and positive – and that's the system working really.

Internationally-recognised best practice for continuity of care to prisoners on their release is summarised in Appendix IV.

Recommendations

The NHC recommends that to improve the continuity of health care and disability support when prisoners enter, transfer between, and leave prisons:

10 The agency responsible for primary health and disability support services in prisons takes responsibility for ensuring seamless continuity of care, including:
   a the timely transfer of health-related information into, between and out of prison(s)
   b in preparation for release from prison, active referral to community providers
   c using Whānau Ora principles to guide continuity of care.

11 The health and support needs of the prisoner are given serious consideration when an inter-prison transfer is being considered.

10 Strengthen relationships and address responsibility for prisoner health

This section stresses the need for stronger relationships between agencies. It recommends that serious consideration be given to transferring responsibility for primary health care for prisoners to the Ministry of Health.

10.1 Improve cross-agency arrangements

10.1.1 Strengthen relationship between Ministry of Health and Department of Corrections

Regardless which agency manages primary health care within prisons, the relationship between the Department of Corrections and the Ministry of Health is critical to the effectiveness of that service.

Realising the principle of equivalence of care based on needs requires a commitment from all levels of the health and corrections systems. It also requires meaningful dialogue between agencies about how to achieve the goal of improved health for prisoners and their families and whānau.

Therefore, the NHC recommends that the chief executives of the Ministries of Health and Justice and the Department of Corrections meet regularly to monitor and review:

- the standard of health care and disability supports for prisoners

- opportunities for improving the health of prisoners and their families and whānau
- lead progress in developing health promoting prisons.

To ensure the needs of Māori, Pacific, and women prisoners are met, the chief executives of Te Puni Kōkiri and the Ministries of Pacific Island Affairs and Women's Affairs should take part in these regular meetings. To ensure concerns relating to young prisoners and to prisoners' families are addressed, chief executives from the Ministries of Youth Development and Social Development should also be involved.

Leadership from the Ministry of Health and Department of Corrections is fundamental to ensuring that prisoner health is a priority for both departments. Joint groups of officials are necessary to advise the chief executives group and to carry out plans together.

In New Zealand, the beginnings of such a joint approach are already laid out in the HANZOFF (strategic) and HANZON (operational) joint departmental working groups that oversee project work. Participants in these groups need support and authority from their organisation's leadership. The terms of reference for both groups need to be expanded to include all prison practice with the potential to affect health, and the planning and implementation of health-promoting policies and practices for prisons. Rather than discouraging decisions that might affect existing policy, the terms should assure a process within each agency for serious consideration of HANZOFF and HANZON decisions affecting agency policy. These decisions will have been made for good reasons. The groups will also play an important role in managing an effective transition and ongoing joint governance, should the Government decide to transfer responsibility for primary health care to the health sector.[293]

10.1.2 Establish a new framework for prisoner health

The memorandum of understanding between the Ministry of Health and Department of Corrections has led to improved mutual understanding about areas of departmental responsibility. However, the memorandum has not clarified responsibilities in some key areas,[294] and does not contain a coherent plan for an effective prison health system in continuous improvement.

The NHC recommends the Ministry of Health leads the joint development of a framework and vision for the prison health system. This should be done in consultation with affected DHBs. The framework would replace the memorandum of understanding. The purpose of the framework is to reinforce the alignment of the prison health system with the mainstream health system and strengthen the emphasis on health services for prisoners in both systems.

The framework needs to:

- clarify roles and responsibilities among agencies
- clarify roles and responsibilities of health staff as distinct from corrections staff
- set clear objectives for the short, medium, and long term
- include means for the regular reporting of health services and disability support provided to prisoners and means for ensuring service delivery is adequate (see sections 8.2 and 9.2)

- establish clear standards for accountability and mechanisms for ensuring accountability
- establish standards of care, quality frameworks, and information management processes that are aligned with the health system (see section 9.1)
- establish a path toward training and professional support for prison health professionals (see section 9.1.6)
- recognise and plan for the different health service and treatment needs and addiction and offending pathways of different prisoner populations, in particular Māori, Pacific, female, older, and youth prisoners
- recognise the role families and whānau play in care planning, and in care maintenance after a prisoner's release and encourage increased family and whānau participation in this planning (see sections 11–13).

The NHC suggests that input also be sought from other government agencies (eg, the Accident Compensation Corporation) and non-governmental organisations (eg, the Prisoners Aid and Rehabilitation Society and the Howard League).

Recommendations

The NHC recommends that to align accountability for prisoner health with accountability for the health of the general population:

5 The chief executives of the Ministries of Health, and Justice, Department of Corrections and other relevant government agencies (eg, Te Puni Kōkiri) meet regularly to:
   a ensure effective monitoring and review of health and disability services for prisoners
   b identify how agencies can work together to improve outcomes for prisoners and their families and whānau
   c lead the establishment of health-promoting prison policies and practices.

6 The terms of reference of the HANZON and HANZOFF joint departmental working groups are widened to include prison practices that affect the health of prisoners, including health-promoting prison action plans in each prison.

7 The Ministry of Health leads, in partnership with the Department of Corrections, the development of a new framework for the delivery of health and disability services to prisoners. Input from other government agencies and non-governmental organisations is sought as appropriate.

10.2 Transfer responsibility for prison primary health care to the health sector

The NHC recommends that the feasibility of transferring responsibility for primary health care in prisons to the health sector is investigated. This section sets out the case for change.

Several jurisdictions have encountered a similar set of problems to those found in New Zealand and have realigned accountability to match core state service roles. Primary (and secondary and tertiary as well as mental) health care in prisons is governed by the state health agency in England and Wales, France, Norway, and the Australian states of New South Wales, South

Australia, Queensland, Northern Territory and Tasmania. Scotland and Spain are preparing for similar moves.

When the health care of prisoners has been shifted to the state health agency and the roles of health and custody have been separated and clarified, there have been demonstrable improvements in prisoner care and health outcomes. While it is not always possible to establish singular causal connections between institutional change and improved outcomes, the overall impression gained by the NHC was of substantive improvement as a result of the changed institutional arrangements.

The NHC believes that transferring responsibility for prisoner primary health care services to the health sector would mean:

- alignment between activities and organisational objectives
- better support for health staff
- better and more consistent care both for individuals and for a high needs population
- better continuity of care between prisons and between prisons and the rest of the community
- more efficient services
- increased accountability for the health of prisoners
- public health gains.

10.2.1 Alignment between activities and organisational objectives

The central problem has been identified as twofold:[295]

> Prisons do not adequately cover prisoners' health care needs because it is not a core business activity and thus not a priority.
>
> Health does not adequately cover the health care needs of prisoners because ... prisoners are not part of their mandate and thus their care is not a priority.

An inherent tension exists between a custodial role and the delivery of comprehensive, high-quality health services, including prevention and health promotion. Prison is necessarily hierarchical and security-focused, so fundamentally disempowering for inmates. The objective of the Department of Corrections is to 'ensure offenders are managed safely and humanely'. Though the department attempts to provide health care 'comparable to that which the general community receives', its annual report makes no mention of health protection, promotion, or improvement.[296]

Although staff and officials responsible for prisoner health are committed, caring professionals, current institutional arrangements prevent medical professionals from fully exercising their duty of care. They also place an inappropriate burden on custodial staff. For instance, in prisons with no nursing staff on site at night, a senior duty officer responds to prisoner calls, determines if a medical emergency is in effect, calls an ambulance or health professional, and administers emergency life support or stabilisation treatment.

In Queensland, a change in accountability for prison health services has shifted the institutional focus, 'The focus used to be on security ... Now it is shared – health is equal'.[297]

The current division of responsibilities has meant strategic documents for New Zealand's public health, primary health, mental health, and addiction treatment health systems tend to make only a passing mention of prisoners as a health clientele, and usually do not refer to the prison health services.

Post-transition, major health initiatives in the state health sector in England and Wales now address prisoners as a patient group with specific needs and opportunities for intervention,[298] and the Department of Health recently launched the first comprehensive strategy for health care incorporating offenders.[299] In Australia, a rising profile for prisoner health led to prisoners' inclusion in the national hepatitis C and HIV/AIDS strategies[300] and a national prisoner health census.[301]

Overseas jurisdictions that have changed their prison health services to health-led models report a shift in focus from episodic, reactive medicine to a primary health care model, with a focus on prevention. Queensland, for instance, reports improved links with cancer screening programmes, tobacco initiatives, and alcohol and other drug services.

Regular audits, incident trending, a council for clinical review, and new assessment tools have been used to maintain quality standards in prison clinics in line with those in the health sector.[302] New dedicated areas of work, such as (in England and Wales) a women's health workstream, an environmental health officer, and a directorate for adolescent health, promise improvements in areas of special need for prisoners.[303]

Government funds the health sector to develop clinical knowledge and networking, best practice guidelines, clinical pathways, prevention and health promotion expertise, expertise in areas such as Māori health, Pacific health, youth, women, and older people's health issues. This expertise, and systems integration for continuity of care among primary and secondary health care providers, could make a strong contribution to the expertise already held within the corrections health service.

10.2.2 Better support for health staff

Making prison health staff part of the health workforce, guided by the objectives of the health and disability system, will enable them to carry out their professional duties independently. More health sector professionals working in prisons will encourage alignment between the medical care facilities in prison and those in the community.[304]

Before the transfer of responsibilities in England and Wales, many prison nurses were disenfranchised from the nursing community. The transition process introduced a nursing strategy, development in nursing roles and specialties, a health care skills toolkit to define and assess competencies, and national nurse, doctor, and pharmacist networks. The nurse and doctor clinical networks have now developed regionally. 'Now you have a lot of nurses with high degrees of professionalism ... and schools of nursing doing placements in prisons. It keeps

it fresh.'[305] Health care managers have also benefited from the increased involvement of the National Health Service.[306] Offender Health Services in Queensland has a similar experience. There, a new clinical nurse educator role has been established to assess nursing roles and future needs and develop training packages and accountability mechanisms.[307]

Bringing prison health staff into the health 'fold' increases nurses' access to training and resources. The United Kingdom now incorporates prison health professionals into major nationally led training programmes for communicable disease, mental health awareness, and other health topics.[308] In Queensland, the annual training budget for prison nurses has risen from $50 to $1500 per nurse.[309]

Flexibility and innovation are supported when health care is delivered within a health-led system. New South Wales explored this with a new, nurse-led model for hepatitis C treatment. This model has shown 'excellent results'.[310]

Shifting ownership of the health service elevates the profile of prison health experts and enables them to share important knowledge with others in the sector. In France, some staff members at a new national institute for preventive medicine and health education are prison health specialists.[311]

Reduced professional isolation for prison nurses has attracted many nurses to employment within prisons.[312] Prison health services in New South Wales can recruit staff more easily, because staff can see more opportunity for career development, including in research and teaching, knowing that their expertise is valued.[313]

10.2.3 Better care

The delivery of quality care is one measure of a high-performing health and disability system. A high standard of health care is maintained through both quality assurance activities and continuous quality improvement. Achievements in these areas can be signalled by improvements in performance, rising patient participation and by improvements in service and health outcomes.

Performance improvements

In England and Wales, the transfer of responsibility for prison health services to local primary care trusts was accompanied by a call for these services to be delivered to the same clinical standard as any community health service.[314] The transition process initiated a performance improvement monitoring process that lifted the quality of care in 17 prisons from the lowest performance category between 1999 and 2003.[315] Over the course of the transition, the United Kingdom's Prison Inspectorate has reported considerable improvement in overall health service among public sector prisons.[316] A survey of prison–primary care trusts partnerships found that 'across the board there is a perception [since the transition] that there has been a general improvement in the quality and efficacy of health care provided to people in prison'.[317] Evaluations conducted in the France, Norway, and New South Wales prison health services also showed improvements in the standard of care.[318]

The transition process can support improvement when problems were previously invisible, as in France where it led to a range of outpatient mental health interventions for prisoners.[319] New South Wales conducted comprehensive Inmate Health Surveys in 1996, 2001, and 2008 to highlight health needs and guide service planning.[320]

Positive culture, improved trust

In England and Wales, the role of performance management, targets and the 'decency agenda'[321] helped to shift a generally negative culture among health staff.[322] The health service was seen as playing a key part in change to the prison culture as its relevance became more visible and as health staff made more links, for instance, with resettlement services in every prison.[323]

The role of the provider to act as an advocate for the health and disability needs of their patient is an essential component of competent health care, and trust among patients for their provider is essential to the service's effectiveness. In Queensland and NSW, patients are more willing to attend the clinic and more open with their concerns now that the division of staff responsibilities is clear to staff and apparent to prisoners. Clinical leaders also believe access to health services is more timely and that quality overall is improving.[324] 'Incredibly high' uptake rates for a trio of immunisations offered in NSW is another measure of the level of trust nurses have built with patients.[325]

Health and service outcome improvements

The partnerships between prisons and primary care trusts in England and Wales showed significant improvements particularly to primary health care services,[326] and response to acute mental illness.[327] For the first time, the in-prison drug use rate went below 10 percent, and deaths in prison declined as well.[328] Assault and suicide rates and heart attacks are also reportedly lower since the transition. Communicable disease control and chronic disease prevention took on a higher priority, with comprehensive hepatitis B screening, active health promotion initiatives and a successful smoking cessation programme now in place (initial evaluations documented an average quit rate of 41 percent at four weeks across 16 prisons).[329] Immunisation uptake and quit rates among young men are both reported to be far better in prison than in the prisoners' home communities.[330]

The stronger focus on assessment, prevention and early intervention in Queensland means that all people over 45 years entering prison who are identified as having Aboriginal or Torres Strait Islander ancestry now receive an electrocardiograph, and wellness clinics provide detailed preventive education or help prisoners learn how to manage their illnesses. The needs of people aging in prison have been identified and agency responsibilities clarified.[331]

Better continuity of care

Disrupted therapeutic relationships or lack of support on release can quickly unravel health gains achieved in prison. A transfer of responsibility for health services to the health sector improved continuity of care in Queensland, where 'more thought is given to what happens when [long-term prisoners or prisoners with multiple health conditions] leave'.[332]

Continuity of care has been a strong focus in New South Wales, where people at risk of self-harm are identified and supported back into the community, and a coordinated release planning programme for drug users has significantly improved health outcomes and reduced reoffending.[333]

The transfer can make it easier for the prison health team to gain places for prisoners in community mental health, alcohol and other drug, or other services as they leave. In New South Wales, for instance, health staff developed a 'discharge' summary for released prisoners and enabled health workers inside prisons to follow up with released prisoners with ongoing drug or mental health problems, encouraging formerly reluctant community services to work with former prisoners.[334]

The health sector in New Zealand is already exploring the contribution it can make to continuity of care and successful reintegration (see Box 10.1).

Box 10.1: Manaaki Whakaora Health Navigator Pilot Programme, New Zealand

Manaaki Whakaora Health Navigator Pilot Programme was introduced by the Whanganui Regional Primary Health Organisation (WRPHO) in April 2009. The programme takes a collaborative and holistic approach to continuity of care for released prisoners, working closely with prison clinic staff and community providers. Its goal is to assist prisoners in a smooth return to the community and to wellbeing. The Whānau Ora model is reflected as the team walks alongside the client and their family as they set their own goals and find their own solutions.

Clients have a 'health navigator' (community health worker) who meets with them before release. The wellness plan they create together can include any area of life: health, family, employment, housing, transport, welfare, life skills and training options. Clients identify goals such as 'being a good husband and father', 'get a job', 'reconnecting with family' or 'getting a birth certificate in order to access WINZ assistance'. Health navigators then assist clients and whānau to access primary health care and other services. Forty-nine of the 63 pilot programme participants had not been registered with a general practice when they entered the programme.

'W was fed up with the "revolving door" of prison and wanted to change for his child's sake. He had no GP, poorly managed asthma and alcohol and drug issues. In the past he had tended to use the emergency department when he needed inhalers. Manaaki Whakaora "listened and explained things at my level ... They made sure I understood what they had been talking about." The wellness action plan W created with the support of the Health Navigator has led to him registering with a GP, obtaining and learning to use asthma medications, getting professional help with his anger and alcohol and drug problems, and connecting with support for legal, training, housing and benefit enquiries he had had. W organised and held a whānau picnic day as a first step to reconciling with his whānau.'

The team provides a broad range of supports, for instance budgeting, social skills, problem solving, smoking cessation, health education, whānau support, help with the IRD and bank accounts, benefits, and court support. Clients have made meaningful connections through the programme, which helps builds their trust in providers. The programme plays a supporting role to existing services, many of whom are under pressure.

A formative evaluation has shown positive outcomes.[335]

Manaaki Whakaora is a superb innovation, but it is vulnerable to funding pressures. Initiatives of this nature are not common – in part because prisoner health care is not prioritised in the New Zealand health sector.

More efficient service

The NHC believes that transferring the funding and delivery of prisoner primary health care to the health sector has the potential to produce efficiency gains.

Earlier detection of health needs and appropriate treatment before health conditions worsen will save significant health costs in the long term. Improved integration and communication between the primary health care services provided in prisons and services in the community will save in the short term.

The Department of Corrections pays a premium for many services. The ability to purchase in bulk, negotiate regionally for services, or plan nationally for capital purchases allows the health system to benefit from its large scale. By way of comparison, on any given day the nation's prison population is a health clientele equivalent to about one-quarter of New Zealand's smallest DHB (West Coast DHB). In Queensland, savings were made soon after prison health services came within the ambit of Queensland Health.[336]

Any transfer of prisoner primary health care to the health sector should produce cost savings where systems and procedures such as purchasing functions are duplicated by the Department of Corrections. Improving systems for prisoners will also save on invisible costs currently borne by the health system such as missed specialist appointments due to lack of coordination, poor communication, or inappropriate prisoner transfer.

Better accountability for the health of prisoners

Accountability for prison health services should be to the health sector. The health sector has the necessary expertise to guide best practice, monitor the quality of care, balance competing health priorities, and provide accountability to the public.[337]

Accountability for improving prisoner health lies with the individual health practitioners responsible for following best practice, the officials responsible for guiding and monitoring the prisoner health service, and ultimately with government – to achieve the objectives of the health and disability system.

The NHC believes that accountability for health outcomes within the Corrections–led system is weak on all of these fronts. For example, the department is only in the early stages of developing best practice templates for nurses and medical officers in assessing prisoner health needs and determining care plans. The degree of accountability each prison has to the department for the use of funding (eg, in spending on oral health care) appears to vary, according to the efforts of individual health staff and prison management.

Leaders from jurisdictions that have made the transition from prison to state health services uniformly emphasise the importance of strong partnerships between the health and corrections agencies at the highest levels of leadership.[338] This level of accountability for both agencies has fostered better results for patients in the United Kingdom, for instance, because doctors' clinical judgements are respected by prison governors and rarely overruled – although they can be in emergencies.[339] Another foundation recommended by some is a governance framework grounded in legislation. Leaders of Justice Health in New South Wales believe it owes its effectiveness to the legislation that is the basis for the organisation.[340]

The NHC commends the efforts by the Department of Corrections to improve accountability through changes to management structure, development of clinical leadership positions and quality improvement initiatives. However, the NHC believes that a Corrections-led health service will always have difficulty reconciling a comprehensive approach to health with its custodial imperative. Moreover, jurisdictions in which health services are privately contracted have found that monitoring and accountability can be even more difficult as contract and health information tend to be covered by 'commercial-in-confidence' clauses.[341]

Accountability for improving the health of prisoners should rest with the Ministry of Health as the agency responsible for achieving the objectives of the New Zealand Health and Disability Act 2000 on behalf of the people of New Zealand. Funder, policy agency, and providers should be accountable to all health sector standards just as they are for any other part of the health service. This makes sense from the perspectives of the patient, the Ministry of Health, and the Department of Corrections.

Creating a sensible accountability pathway for health is not a panacea, but it is an essential step toward ensuring that public agencies are responsible for the business they each know best.

Public health gains

The problem of poor prisoner health extends well beyond the Department of Corrections and the criminal justice system in its effects. The 2003 Moscow Declaration, by the states of World Health Organization Europe and the Russian Federation, outlined the problem:[342]

> In all countries of the world, it is people from the poorest and most marginalised sections of the population who make up the bulk of those serving prison sentences, and many of them therefore have diseases such as tuberculosis, sexually transmitted infections, HIV/AIDS and mental disorders. These diseases are frequently diagnosed at a late stage. In addition, no country can afford to ignore widespread precursors of disease in prisons such as overcrowding, inadequate nutrition and unsatisfactory conditions.

There is a whole-of-society cost arising from poor prisoner health. This affects families in every town and city, threatens communities, damages child health and social outcomes, and creates challenges for numerous government agencies. At present, New Zealand does not even have measures in place to assess post-release mortality or health outcomes:[343]

> Well-targeted health expenditure should properly be seen as a down payment towards the reduction of future health care costs that would be incurred by that population following release into the community.

Once prisoners have 'done their time', they return to families and communities. Those who have participated in effective health education take these understandings home to their families. Freedom from communicable disease, addiction or depression, or being equipped with ways to manage chronic disease or overcome hearing impairment have a lot to do with how well their children fare, and whether or not they will follow their parent to prison.

Leadership by, and involvement of, the community of health professionals will ensure that prisoner health care goes beyond service delivery to individuals. Matters of public welfare such as infectious disease control and preventive medicine require health professionals to be closely involved with policy development. Strengthened links owing to the transition process allow for more effective collaboration for the public good, as the UK Department of Health found when prison data assisted in a large London-area tuberculosis tracing and management project.[344]

> A health service model that looks inwards, concerned with patients only whilst they remain prisoners, is not well-equipped to meet widely agreed public health standards.[345]

Better health is influenced in turn by prison diet and exercise, isolation and bullying, hygiene, overcrowding, and harm minimisation strategies. Improved communication and integration among Corrections authorities, health services within prison and agencies outside prison is vital if these matters are to be addressed in a coherent and effective way.

Though needing convincing before the switch in responsibility, a clinical director in Queensland Health Offender Health Services now says:[346]

> We would never go back. Neither us nor the nurses who were hardest to convince. It's been extremely beneficial for patients and staff.

Recommendation

The NHC recommends that to align accountability for prisoner health with accountability for the health of the general population:

4 The Minister of Health directs officials to investigate the feasibility, benefits, cost, and other implications of transferring responsibility for policy development, funding, and oversight of the provision of primary health care for prisoners from the Department of Corrections to the Ministry of Health and the National Health Board.

10.2.5 Possibilities for a new structure

The NHC has considered earlier work by officials, including consultation results, assessing the options for placement of primary health care services for prisoners within the health sector. The NHC does not wish to pre-empt the terms or findings of any investigation into a new structure, so presents the following as a contribution to future policy work.

Funding held at national level

The current primary health service has a nationally managed budget, although many services are contracted separately by individual prisons. The NHC considers that until the Ministry of Health has an in-depth understanding of the nature of the service and how any funding might be devolved, it would be appropriate to continue to manage the funding at a national level. This eliminates any risk that funding decisions will affect other areas of DHB funding or that DHB priorities will crowd out prisoner health.

A nationally-funded service is considered most appropriate at this time because:

- it will minimise the transition costs – the service is likely to be more effectively delivered if initially specified as a distinct service with ring-fenced funding
- the prisoner population frequently moves among DHBs, making devolved funding through capitated and adjusted funding formulae difficult to administer
- DHBs are not all positioned equally well to take responsibility for the health of prisoners within their populations
- the disruption to DHBs will be minimised if policy is developed before a decision to devolve responsibility is made.

Policy development by a dedicated Ministry of Health team

To avoid the risk of prisoner health concerns being overlooked within the broader concerns and competing priorities of the health sector, it would be essential to maintain a dedicated policy team for prisoner health. This team would sit within the Ministry of Health. The team would provide coherent policy development with clear objectives and timeframes for lifting performance and, ultimately, health outcomes across prisons.

As the home of institutional knowledge required to respond to the complex health needs arising within the unique context of prison, the team would need to have:

- an understanding of the legislative and regulatory framework
- an understanding of the relationships established and needed among government, non-government and provider organisations
- an understanding of the intersections with the health system along the criminal justice pathway
- expertise in primary health care and public health policy
- knowledge of institutional arrangements for mental health, intellectual disability secure care and alcohol and other drug addiction treatment
- expertise in international developments in prisoner health and care delivery
- awareness of the unique context in which prison-based or in-reach services must operate
- responsibility for maintenance of essential cross-agency relationships.

Prison has a significant effect on the health of its residents, and prison culture has an impact on access and service delivery (see sections 5.3 and 7.5). Principles of culturally appropriate policy making and service delivery apply to this culture as well. If policy and procedure are to be effective, policy makers must have sound knowledge of the social, institutional, and cultural realities of prison. This can be achieved only if there is a policy 'home' for prisoner health.

One national prisoner primary health care provider

Because consistent service delivery across prisons is a crucial first step to improving performance, only one provider would be engaged initially. Improvements in service management thus far have been linked to the change in existing corrections health staff hierarchy, which created uniform accountabilities to a national manager.

It would take time before multiple providers could deliver services effectively because:

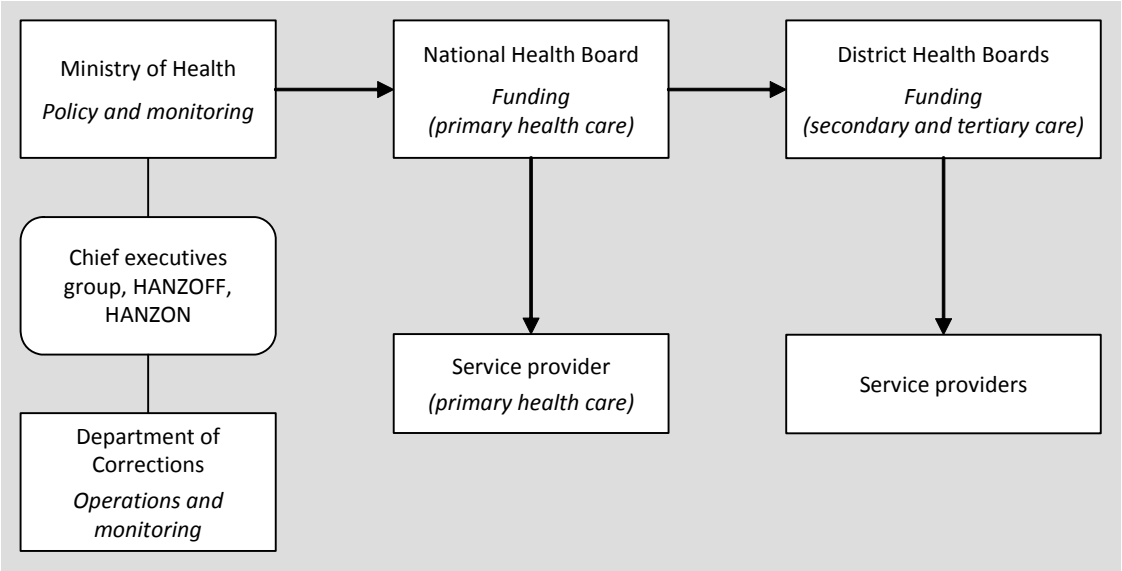
- consistent service provision and quality standards need to be established and embedded
- the basis for reliable national data collection and analysis and for information sharing remains to be established
- the prisoner primary health care service is different from that delivered to the general population, so clinical and contextual expertise must be developed.

This would not preclude the service provider from maintaining contractual relationships with community providers such as allied health services or from developing relationships with local Whānau Ora practitioners.

The prisoner population is a high-needs group in a controlled environment. It is in many ways an ideal opportunity for targeted health interventions to improve health outcomes among those most at risk and to reduce health inequalities among the general population. National funding and policy making with a single service provider would allow monitoring and evaluation of nationwide service delivery and targeted changes to that service delivery.

A configuration of primary health care to prisoners is suggested in Figure 10.1.

Figure 10.1: Suggested configuration of primary health care to prisoners



Part Three: Families and Whānau, Children, and Communities

11 Introduction to Part Three

The NHC believes that when the state intervenes by arresting and imprisoning a citizen, then the state must also assume a level of responsibility for some of the consequences of this action. This is particularly important when the incarceration affects the health and wellbeing of children left behind in the community. The damaging effects on the prisoner and family members are often mutually reinforcing:

> Heard my son's wetting the bed; he's insecure about all this and that's not good for my boy. This is the effect I was talking about, and [my other child] calling out for me, I feel sad about all of these things and can't do anything about it. All my feelings revolve around the whānau and how all of this is damaging their life; f** it all, depression kicks in and eats you up inside.
>
> Hohepa, Māori man, 20–30 years (in a letter)

The families and whānau of prisoners tend to be among the poorest in society. They are often in crisis before the arrest occurs, in poor health, and under significant stress. The arrest of a family or whānau member adds additional financial and emotional stresses. These stresses affect family relationships, the ability of the family or whānau to cope, and the health of individual family members. These factors also increase the likelihood of children developing serious emotional and behavioural problems.[347]

Imprisonment affects communities as well as families. As has been noted earlier in this report, the most vulnerable communities are more susceptible to the cycle of imprisonment. High imprisonment rates can erode the stability and cohesion of the whole community. The large proportion of Māori in New Zealand prisons means the impacts of imprisonment fall disproportionately on Māori whānau and communities, and result in many living on the verge of crisis. This cycle is also becoming a pattern in some Pacific communities. The vulnerability of communities is evident when people return from prison with gang connections, and families and communities have to choose whether to exclude people or invite gang influence.[348]

Most prisoners remain members of families and wider community networks while they are in prison. Often these networks weaken while a person is imprisoned, particularly if they are 'inside' for a long time, are a long way away from their home, move prisons frequently, or committed a crime against a family member.

Family and community relationships play a strong role in the resilience of prisoners. These relationships are critical for maintaining a prisoner's social networks and identity. Secure identity is a prerequisite for health and wellbeing and cultural identity not only depends on access to culture and heritage, but also on the opportunity for cultural expression and cultural endorsement.[349]

Focusing on the family and whānau rather than just the prisoner provides opportunities for lifestyle change among family and whānau as well as offering a means for healing. For Māori families, this may involve resolution of hurts, restoration of relationships and reconstruction of whānau values and mana.[350]

Prison policies, health services for prisoners, and government and community support services can all play a part in enhancing the health and wellbeing of prisoners' family and whānau, and help prisoners retain and strengthen their relationships with their families and communities.

12 Effect of incarceration on prisoners' family and whānau

Family and whānau members are affected emotionally, physically, and financially by imprisonment.

Before the incarceration, many of these families and whānau were already dealing with the challenges of alcohol and other drug abuse, unhealthy lifestyles and living environments, members with mental health problems, and environments of physical and mental abuse.[351] Financial pressures, loss of parenting support, and the stigma of imprisonment accentuate these challenges and increase the risk of poor health, criminogenic behaviour, and social exclusion. There are often significant challenges in keeping contact with and visiting the family member in prison, and new hurdles when the prisoner is released.

12.1 Effects on health and wellbeing

Recently, three New Zealand studies have examined aspects of the effects of imprisonment on families.[352] All three studies found that incarceration affects the health and wellbeing of families.

The Invisible Children report notes that, 'the overwhelming picture was of a population with multiple health problems that were getting worse'.[353] This scenario is consistent with international literature, which describes already fragile families being stretched financially and emotionally, frequently to breaking point.[354]

In a few instances, the New Zealand research found some health benefits to having a family member in prison. For example, children may get better nourishment, and those with asthma may be able to live in smoke-free environments.[355] For some families, imprisonment results in relief from domestic violence.[356]

12.2 Maintaining contact with the prisoner

Worry about the prisoner's wellbeing and the challenge of maintaining contact during imprisonment have significant emotional and financial impacts on family and whānau members. Prison policies and practices mean communication with families and whānau regarding prisoner health and wellbeing is poor:[357]

> Q: When you ring the prison for information what do they say?
>
> A: That I have no right to know, so I wait for [my son] to let me know.
>
> Parent of prisoner

It can be difficult and expensive to maintain contact. Distance, cost, and the visiting arrangements mean visits may take place infrequently. Placing a toll call from a prison costs 0.99 cents a minute (using a phone card). This cost is usually met by family members as prisoners do not tend to have an income and those that do only earn a maximum of $25 per week. Family members often go without necessities (such as food or doctors' visits) to be able to regularly visit the prison or provide prisoners with money for phone cards and other consumables.[358]

12.3 When the prisoner is released

Release from prison can be very stressful for families and whānau. Spouses or partners in the community may have developed new independence and taken on new roles. Former prisoners usually expect a seamless transition back into their old roles – and can respond negatively, even violently, to the difference between expectations and reality. For instance, it is common for prisoners to develop 'hair-trigger tempers', which produces inappropriate behaviour in a family setting. Family members may actively prevent a former prisoner from reconnecting with the prisoner's children.[359]

The health status of the released prisoner may directly affect the health of the people they live with, for instance, if the prisoner has an alcohol or other drug addiction, a mental health condition, or has contracted a communicable disease in prison. This is particularly true for women, who are more likely to be the primary (or sole) caregiver of children. Poor health and needs relating to health care will stretch the family's limited resources.

12.4 Health effects on children of prisoners

When a child's parent or primary caregiver goes into prison, this can affect not only their living arrangements but also their health and wellbeing:[360]

> They just miss Dad. Since he has gone they are bed wetting, sleep walking, having anger, bad dreams and desperation. These are all completely new problems that they never had before.

The extent to which children are directly affected by the imprisonment of a family member depends on the family situation, in particular:

- how much their living arrangements are disrupted by the imprisonment
- how much contact they had, and the closeness of their relationship, with the imprisoned family member
- other simultaneous events, such as witnessing a parent's violent behaviour or being present during the arrest and required to provide a statement.

Even after release from prison, the relationship between the incarcerated parent and their children can still be difficult:[361]

> This was a stressful period of readjustment for both child and parent and sometimes resulted in parents and children withdrawing from one another or a sense of a loss of control and hopelessness by the parent in seeking to re-establish the relationship with their child or children.

Research participants commented that the effects of incarceration were lessened when the child had regular and frequent positive contact with their parent in prison and when they received counselling.[362]

12.4.1 Physical health

Diseases such as asthma, eczema, psoriasis, and other skin and nervous disorders are common among children of prisoners. Parents reported that the 'children's health worsened as a result of parental imprisonment or, sometimes, the abuse experiences they had living with the parent prior to prison'.[363] Some young people related their alcohol and other drug use to the imprisonment of a family member.[364]

On the other hand, the imprisonment of parents with extreme alcohol and other drug use may result in more routine in the home, children attending school regularly, and children having better nutrition.[365]

12.4.2 Emotional health

Sadness, hurt, anger, resentment, relief, shame, and embarrassment are among the emotions experienced by children of prisoners.[366] When a family member goes into prison, some children respond with bed-wetting, nightmares, anxiety, and depression.[367] Some children and young people become aggressive and challenging; others are withdrawn and unwilling to talk about their parent in prison or their feelings about this.[368]

These problems were 'considered, if not normal, something that the families must live with' and it was noted that these families tend to live in poverty and had high levels of stress that appear to intensify health problems.[369] The emotional reactions experienced by prisoner's children 'were believed to be compounded by the visiting process, which portrayed their parents negatively and prevented them from showing affection'.[370]

12.4.3 Impacts vary with the age of the child

New Zealand studies have found that the impacts of imprisonment differ depending on the age of the children. From analysis of its interviews with prisoners and family members, Litmus Ltd developed Table 12.1.[371] These relationships between age and the type of impact are consistent other research in New Zealand and overseas.[372] It is distressing to note that many of these behaviours are themselves, or are recognised as potential precursors to, offending behaviours.

Table 12.1: Impacts of incarceration on prisoners' children by age group

Age of child	Impacts of incarceration
0–3 years	Low degree of attachment to incarcerated parent and loss of bond Separation anxiety
4–7 years	Separation anxiety Bedwetting Night terrors Aggression and violence Lack of engagement in school
8–10 years	Aggression and violence Feeling depressed Truancy
11–15 years	Violence Assuming the role of the absent parent or parenting the parent Truancy Decreased academic achievement

Source: Roguski and Chauvel (2009, p ix).

12.5 Effects on older family members

When imprisonment results in changes to care arrangements for children, it is often grandparents who take on an increased role in childcare. This may be as the primary carer or in providing extra support to their grandchildren. Often grandparents take over childcare at a time of life when the physical and emotional toll of parenting is likely to be higher than it would have been in their younger years.

Recent research by the Families Commission on grandparents in New Zealand found that 'some grandparents experience considerable pressure and challenges integrating their grandparenting role with other aspects of their lives'.[373]

> The eldest has been in and out of jail, and when parents go away to visit, we're there to support the other kids, and we supply all the money. We do not like that too much.[374]

Many parents of adult prisoners have to deal with being caregivers for their grandchildren and making financial contributions to the family as well as fulfilling their own role of sharing traditional practices and wisdom with their grandchildren or mokopuna. These combined pressures and coping mechanisms, such as 'going without' to make ends meet, negatively affect the grandparents' health. The Families Commission report identified that grandparents raising grandchildren need 'access to counselling, regular respite care, and ... subsidised out-of-school care and recreation programmes'.[375]

13 Focusing on family and whānau of prisoners

Part One described the variety of family and community settings in which prisoners live before incarceration. In designing services for prisoners and their families it is important to take into account this diversity.

A focus on family and whānau is essential both for the health of the prisoner and the health of family and whānau members. This focus can be achieved by building the capacity and resilience and by providing health and support services that are appropriate for the circumstances, reality, and experiences of the prisoner's family and whānau. This focus has the potential to address many of the health problems intrinsically linked with incarceration (such as alcohol and other drug abuse and mental health conditions) and to design appropriate services.

New Zealand research suggests families are largely invisible in the criminal justice process, and that contact between prisoners and their families is circumscribed.[376] Some overseas jurisdictions have placed families more centrally in their corrections policy. For instance, Correctional Service Canada includes obligations towards families of offenders:[377]

> at **every step of managing offenders' sentences** from decisions around placements to factors that determine correctional plans and guide case management, to community contacts within the institutions and in the community, to transfers and parole supervision.

Correctional Service Canada has policies to assist prisoners to maintain and develop family and community ties. For instance, private family visits are offered in preparation for the prisoner's return to the community and to lessen the negative impact of incarceration on family relationships.[378]

The New Zealand Ministry of Justice is working with other government agencies to establish Whānau Ora initiatives. Many of the families and whānau who will be supported through these initiatives will have a member in prison. Whānau Ora initiatives provide an opportunity for agencies to work collaboratively with families and whānau to build the cohesion, capacity, and resilience of those most at risk.

The NHC has identified that a focus on family and whānau involves:

- maintaining effective links between prisoners and their family and whānau
- protecting, promoting, and improving the health of family and whānau members of prisoners.

13.1 Maintain effective links between prisoners and their family and whānau

Maintaining contact with families and whānau during imprisonment through personal visits, telephone calls, and letters is usually important for both the prisoner and their family.

Many prisoners are, or are trying to be, good parents and are aware that maintaining strong family relationships is very important to children.[379] However, the past actions of a few prisoners mean it is inappropriate for them to retain contact with their children or partners.

The information the NHC has gathered has identified that changes to the policies and practices for prison visits, locating prisoners, advising family members when a prisoner is sick or injured, and sentencing and reintegration planning will help to maintain these links.

13.1.1 Prison visits

Family and whānau members consider visits to the prison to be the most meaningful contact.[380] However, the visiting process can be distressing for family members. It is hard for family members to leave their loved one in prison at the end of the visit, and prisoners sometimes discourage their more vulnerable family members from visiting.

The prison environment is generally not 'child friendly', and New Zealand research found that the visiting processes such as searches and restrictions on physical contact have negative effects on children. These effects include anxiety, depression, night terrors, and physically acting out against the prospect of visiting parents.[381] Opportunities for normal family interactions (such as discussions about what children are doing at school or providing advice and support to whānau members) are difficult to create in a prison environment. Overseas jurisdictions have found that creating a child-friendly visiting environment has benefits for all family members.

Prison visits are not always possible. Family members may be banned from visiting because of gang associations or previous criminal activity or because prohibited items have previously been found on a visitor or in a vehicle. Sometimes prisoners are not allowed to receive visitors because they have lost their privileges.

Families also experience barriers when keeping in contact by phone and letter. For instance, phone cards for the prisoner are a significant financial cost for many households. It is not clear why the cost of phone calls from within prisons must be so high.

The NHC understands that videoconferencing with prisoners as a means of supporting justice processes is being explored, and that the Ministry of Health has funded videophones for deaf consumers to trial. With some imagination and coordinated effort, there may be an opportunity to bring parents in prison and children at home together with the use of this technology.

13.1.2 Location of prisoners

People are often imprisoned far away from their home. While the Department of Corrections is required to contact family members to advise where a prisoner is located,[382] prisoners can be moved at short notice, often without the family knowing. These decisions have an impact on prisoners' relationships with their children and other family and whānau.

The NHC suggests that decisions about a prisoners' location need to take into account family and whānau relationships, and family members should be informed as early as possible where prisoners are being transferred.

13.1.3 Knowing when the prisoner is sick or injured

An issue that has been consistently raised in New Zealand research is that family members often do not know when the prisoner is sick or injured and find this distressing. This research and the NHC's discussions with prisoners, former prisoners, and their families suggests more effective processes are needed to inform family members of any health problems the prisoner experiences while incarcerated and to allow them to visit prisoners when they are in hospital.

> When my son went to jail, there was no information about letting us [family] know he got a serious beating that caused him blindness and no one informed me....No information from the prison came at all; I did not know he was in hospital and then it happened again and I did not know.
>
> Parent of prisoner[383]

13.1.4 Care, sentence and reintegration planning

The NHC suggests it would be beneficial to involve family or whānau members in the prisoner's sentence or care planning. This would enable the prisoner to set meaningful goals for their recovery or reintegration in discussion with family or whānau members. For instance, they could be involved in designing the care plans for a prisoner with chronic conditions or addressing the spiritual dimensions of a prisoner's poor health or addiction. Prisoners' privacy is protected just as is the privacy of any patient. Privacy concerns can be addressed by seeking informed consent for health information to be shared with family.

Families participating in the Wesley Community Action study remarked on the 'poor communication and absence of any information to help the former prisoner reintegrate into a family household and society in general'.[384]

Reintegration would be more effective if family and whānau members were involved in the planning. This could include holding a family group conference as part of the reintegration planning to plan for accommodation, health and support needs, and potential impacts on children.

13.2 Protect, promote, and improve the health of family and whānau members of prisoners

13.2.1 Whānau ora approach within prisons

Māori focus units follow a therapeutic community model to support inmates in developing their identification with *te ao* Māori (including te reo, tikanga, and the arts) and motivation for change. These units are beneficial for whānau and iwi. Evaluation showed increased self-awareness, better relationships with close whānau, and unanimity in the view that whānau support is 'very important' in assisting prisoners to avoid reoffending. The Māori focus units were described as:[385]

> encouraging in residents a sense of future-orientation, of looking ahead, [and] planning for their lives in the community, especially in relation to being useful and valuable members of their whānau and iwi.

A Pacific focus unit has been established in the Spring Hill Corrections Facility (Vaka Fa'aola which means the vessel bringing a message of life and growth). The unit is culture-based and aims to increase links with the offender's family, church, and community, vital for their successful integration after release.[386]

Families of prisoners generally have limited resources to access services (such as primary health care) or to proactively look after their health (such as buying healthy food or purchasing medication). These factors have the potential to compound existing or emerging health problems experienced by the prisoner or an immediate family member. Increasing prisoners' control over their own health is likely to contribute to whānau resilience and their capacity to live a healthy life.

13.2.2 Increased support for families and whānau

Many families and whānau of prisoners have developed resilient behaviours and attitudes to cope with the stresses. These approaches may include low levels of confidence and trust in 'helping' organisations. Families and whānau of prisoners tend not to be well linked into health and government-funded support services. New Zealand research shows that the families and whānau of prisoners receive most of their emotional and material support from families and friends. In addition, families use study, work, religious faith, and physical exercise to relieve the emotional stress associated with having a family member in prison.[387]

The Invisible Children report noted that the Ministry of Health funded general initiatives to address the types of problems experienced by the children of prisoners. Most of these initiatives were not adequate to meet the need and no initiative specifically targeted the children of prisoners.[388]

The health and disability sector has a responsibility to the family and whānau members of prisoners, but generally finds it hard to reach these households. Te Tāhuhu, the Government's 2005 mental health strategy, stated:[389]

> Quality services for children and young people acknowledge the wider environment of the child or young person and recognise the need for State services to work together to effectively address those needs.

The NHC suggests that health and other support services need to remove barriers and be flexible and responsive to families' needs. This may involve contracting for services or establishing partnership arrangements with non-governmental organisations, Māori providers, and faith-based groups that provide support to released prisoners and to the family and whānau of prisoners. Effective approaches already exist, such as those of Orongomai Marae (in the Hutt Valley) and the Whānau First model developed by Te Whānau o te Waiperiera Trust in Auckland.[390]

Recommendations

The NHC recommends that to protect, promote, and improve the health of family and whānau of prisoners:

12 The Department of Corrections, as it reviews its policies:

   a identifies ways to encourage greater communication between family and whānau members and prisoners

   b integrates prisoners' family and whānau responsibilities and relationships into prisoner care, sentence and reintegration plans.

13 Government agencies identify how they can best assist the non-governmental organisations, Māori providers, Pacific providers, and faith-based groups that provide support to released prisoners and to the family and whānau of prisoners.

14 Conclusion

The NHC is proud to offer this, its final advice to the Minister of Health. The NHC considers the health and wellbeing of prisoners and their families and whānau to be as important as that of society as a whole. Prisoners are members of the community who are temporarily in prison. Incarceration should be viewed as an opportunity to improve their health and wellbeing and their chances of reintegration, rather than risking consolidation of their membership in a 'criminal class'. New Zealand's reputation as a humane and forward-thinking society can only be enhanced by this approach.

Appendix I: Health Status of Prisoners

Location	Reference	Number of participants	Method	Condition	Prevalence % [95% CI]	Prevalence cf general population [95% CI]
Mental health						
Multinational	Fazel and Danesh (2002)	23,000 prisoners	Systemic review of 62 surveys from developed countries	Psychotic illness Major depression Personality disorder	M: 3.7 [3.3–4.1] F: 4.0 [3.2–5.1] M: 10 [9–11] F: 12 [11–14] M: 65 [61–68] F: 42 [3 45]	2–4 times 2–4 times
Australia	AIEW (Australian Institute of Health and Welfare) (2009)	549 prison entrants, 3,700 prisoners who had visited a clinic, 4,900 prisoners on prescription medicine	Derived from the National Prisoner Health Census 2009	Lifetime prevalence of any mental health condition	M: 35 F: 57	
Australia	ABS (Australian Bureau of Statistics) (2007)	8,800 Australians aged 16–85 years. Including 100 adults who had ever been incarcerated	A general survey of households across Australia. Gives lifetime and past 12-month prevalence estimates for mental disorders	Any mental disorder (last 12 months) – ever incarcerated Affective disorders – (last 12 months) ever incarcerated Anxiety disorders – (last 12 months) ever incarcerated	41 69 28	2.2 times 3.6 times 2.0 times
Canada	Correctional Service Canada (2008)	Unspecified	Routine screening of prisoner's mental health status on intake	Any mental health condition on intake	M: 13 F: 24	
United States	James and Glaze (2006)	14,499 state prisoners, 3,686 federal prisoners, and 6,982 (local) jail inmates	Computer-assisted personal interviewing (CAPI) was used to conduct the interviews at site of incarceration	Any mental health condition – state prison Any mental health condition – federal prison Any mental health condition – local jail	56 45 64	
United Kingdom	Pratt et al (2006)	Identified 382 suicides occurring in 244,988 individuals within one year of release from prison	Compared suicide rates per 100,000 person-years in released prisoners with rates in the general population by using the indirectly age standardised mortality ratio	Suicide		Standardised mortality ratio M: 8.3 [7.5–9.3] F: 35·8 [25·4–50·2]

Location	Reference	Number of participants	Method	Condition	Prevalence % [95% CI]	Prevalence cf general population [95% CI]
United States	Baillargeon et al (2009)	79,211	A retrospective cohort study of prisoners in the state of Texas over a six-year period. Odds ratios were adjusted for gender, age, race, current and previous violent offence classification, current and previous drug-related criminal offence classification and length of current sentence	Four or more incarcerations No major psychiatric disorder Any major psychiatric disorder Major depression Bipolar disorder Schizophrenia Non-schizophrenic psychotic disorders		**Odds ratios** Reference population 2.4 [2.1–2.9] 1.6 [1.3–2.1] 3.3 [2.6–4.2] 2.0 [1.2–3.0] 2.4 [1.7–3.5]
Alcohol and other drug						
Australia, New South Wales	Indig et al (2009)	Random sample 996 men and women in the NSW Corrections Health Service	Stratified random sample. Survey via computer assisted telephone technology	Hazardous or harmful alcohol consumption in year before prison Daily or almost daily drug use in year before prison	M: 62.6 F: 39.8 M: 42.1 F: 54.0	
Multinational	Fazel et al (2006)	7,563 prisoners	Systemic review of 13 studies	Alcohol abuse and dependence	M: 18–30 F: 10–24	
Australia	AIHW (2009)	549 prison entrants, 3,700 prisoners who had visited a clinic, 4,900 prisoners on prescription medicine	Derived from the National Prisoner Health Census 2009. Comparison with the National Drug Strategy Household Survey 2007	Illicit drug use in past 12 months	71	5.5 times
United States	Mumola and Karberg (2006)	14,499 State prisoners, 3,686 Federal prisoners	Computer-assisted personal interviewing (CAPI) was used to conduct the interviews at site of incarceration	Substance abuse – State prison Substance abuse – Federal prison	53 45	
Canada	Correctional Service Canada (2003)	Unspecified	Routine screening of prisoner's health status on intake	Substance abuse – Federal prison	(approximately) 67	

Location	Reference	Number of participants	Method	Condition	Prevalence % [95% CI]	Prevalence cf general population [95% CI]
Chronic disease						
United States	Binswanger et al (2009, p 914)	Jail inmates = 6,582, prison inmates =14,373 and non-institutionalised adults =76,597	Binary and multinomial logistic regression analysis – controlling for confounding factors under three models. Model 1 adjusted for sex and age. Model 2 adjusted for sex, age, race, education, employment status, the USA as birth place, marital status and alcohol consumption. Model 3 further adjusted for smoking status to examine if higher smoking rates	Results for model two – prisoners only hypertension obesity asthma arthritis cancer cervical cancer hepatitis		Odds ratios [95% CI][(a)] 1.17 [1.09–1.27] 0.8 [0.72–0.88] 1.34 [1.22–1.46] 1.66 [1.54–1.80] 1.22 [1.03–1.44] 4.82 [3.74–6.22] 4.23 [3.71–4.82]
Australia	AIHW (2009)	549 prison entrants, 3,700 prisoners who had visited a clinic, 4,900 prisoners on prescription medicine	Derived from the National Prisoner Health Census 2009 – Comparison with the National Health survey 2007–08	Asthma – 25–34 years Asthma – 35–44 years Arthritis – 25–34 years Arthritis – 35–44 years Cardiovascular disease – 25–34 years Cardiovascular disease – 35–44 years Diabetes – 25–34 years Diabetes – 35–44 years Cancer – 25–34 years Cancer – 35–44 years	15 20 5 9 1 4 2 5 1 1	1.5 times 2 times Equal Equal 1.43 times 2 times 4 times 2.5 times 3.3 times Equal
Communicable disease						
Australia New South Wales	Indig (2009, pp 107–108)	Random sample 996 men and women in the NSW Corrections Health Service	Stratified random sample. Survey via computer assisted telephone technology	Hepatitis C antibody Hepatitis B antibody	M: 45.4 F: 28.0 M: 33.8 F: 23.2	
Canada	Canadian Public Health Association (2004)	n/a	Routinely collected surveillance data from the Infectious Diseases Surveillance System	Hepatitis C antibody	M: 23.2 F: 41.2	General population 0.8%
Intellectual disability						

Location	Reference	Number of participants	Method	Condition	Prevalence % [95% CI]	Prevalence cf general population [95% CI]
Multinational	Fazel et al (2008)	11,969	Systemic review of 10 surveys	Intellectual disability	0.5–1.5[(b)]	
Head injury						
Australia	AIHW (2009)	549 prison entrants, 3,700 prisoners who had visited a clinic, 4,900 prisoners on prescription medicine	Derived from the National Prisoner Health Census 2009	Lifetime prevalence of head injury resulting in loss of consciousness	M: 44 F: 33	
Oral health						
United States, Iowa	Boyer et al (2002)	174	Used cross-sectional data regarding untreated decay and missing teeth	Untreated decayed teeth (men and women combined)		8.4 times
Smoking						
Australia	AIHW (2009)	549 prison entrants, 3,700 prisoners who had visited a clinic, 4,900 prisoners on prescription medicine	Derived from the National Prisoner Health Census 2009	Prisoner entrants who are daily smokers	M: 74 F: 67	
Europe	Hartwig et al (2008)	n/a	European Commission report on tobacco smoking includes a review of European studies on smoking rates in prison	Smoking rates in European prisons	64–88	M: 1.5 to 2 times

Notes: All references are in the reference list at the end of the report.

(a) The odds ratio compares the relative odds of a prisoner having a particular condition with the general population after controlling for the confounding factors specified under model two. An odds ratio of one means the prisoner has identical odds of having a health condition to the general population. An odds ratio greater than one means prisoners have elevated odds and an odds ratio less than one means prisoners have lower odds of having a particular health condition.

(b) This is not a pooled average but rather the typical range.

Appendix II: Comparative Analysis of the Health of the Prisoner and New Zealand Populations

Table A2.1: Men – prisoner population compared with New Zealand population adjusted for age

Indicators	Adjusted rate ratios	95% confidence intervals
Schizophrenia	3.88	(1.07–14.00)
Daily smoking	3.21	(2.82–3.66)
Overweight or obese	1.00	(0.92–1.08)
High blood pressure	0.74	(0.46–1.20)
Any chronic disease	0.99	(0.90–1.09)
Heart disease	3.15	(2.16–4.59)
Chronic obstructive pulmonary disease among 45+	2.85	(1.40–5.80)
Asthma	1.30	(0.92–1.84)

Table A2.2: Men – prisoner population compared with New Zealand population adjusted for age and ethnicity

Indicators	Adjusted rate ratios	95% confidence intervals
Schizophrenia	3.67	(1.23–10.95)
Daily smoking	2.81	(2.43–3.26)
Overweight or obese	0.89	(0.81–0.98)
High blood pressure	0.71	(0.44–1.14)
Any chronic disease	1.01	(0.92–1.11)
Heart disease	3.33	(2.28–4.85)
Chronic obstructive pulmonary disease among 45+	2.31	(1.13–4.70)
Asthma	1.28	(0.89–1.83)

Table A2.3: Women – prisoner population compared with New Zealand population adjusted for age

Indicators	Adjusted rate ratios	95% confidence intervals
Schizophrenia	10.07	(1.77–57.46)
Daily smoking	4.74	(4.22–5.32)
Overweight or obese	1.26	(1.07–1.49)
High blood pressure	0.90	(0.41–1.96)
Any chronic disease	0.98	(0.83–1.16)
Heart disease	1.77	(0.56–5.59)
Chronic obstructive pulmonary disease among 45+	0.84	(0.11–6.78)
Asthma	2.16	(1.40–3.33)

Table A2.4: Women – prisoner population compared with New Zealand population adjusted for age and ethnicity

Indicators	Adjusted rate ratios	95% confidence intervals
Schizophrenia	5.44	(0.73–40.26)
Daily smoking	4.36	(3.78–5.03)
Overweight or obese	1.10	(0.90–1.35)
High blood pressure	0.88	(0.40–1.92)
Any chronic disease	0.99	(0.84–1.16)
Heart disease	1.50	(0.46–4.84)
Chronic obstructive pulmonary disease among 45+	0.74	(0.09–6.06)
Asthma	1.96	(1.27–3.04)

Sources: Ministry of Health (2006), Ministry of Health (2008b)

Table A2.5: Specific mental health conditions – prisoner population compared with general population

Lifetime prevalence	Adjusted rate ratios [95% confidence interval]	
	Men	Women
Major depression	1.70[1.42–2.01]	1.53[1.1–2.00]
Post-traumatic stress disorder	5.43[4.52–6.48]	4.26[3.25–5.48]
Obsessive–compulsive disorder	2.81[1.97–3.89]	4.06[2.32–6.60]
Bipolar disorder[(a)]	0.41[0.22–0.69]	0.22[0.03–0.80]

Sources: Oakley Browne et al (2006), Simpson et al (1999)

Notes:

(a) The lower prevalence of bipolar disorder requires further investigation. The NHC derived the results in this table from Oakley Browne et al (2006) and Simpson et al (1999). Simpson found bipolar prevalence was greater in prison than the general population, this is consistent with US evidence presented in Appendix I: Baillargeon et al (2009). Both Oakley Browne et al (2006) and Simpson et al (1999) used the American Psychiatric Association's

diagnostic criteria for mental disorders and the World Health Organization's Composite International Diagnostic Interview (CIDI), although Simpson et al used an earlier version of the CIDI.

A 95 percent confidence interval (CI) means a 95 percent chance that, if we asked the whole population, the true value of the estimate would lie between the lower and upper CI values.

Appendix III: Health Promotion in Prisons – Selected Activities and Outcomes

Health promotion priority	Selected activities/ approaches in jails or prisons	Selected health and social outcomes: inmates	Selected health and social outcomes: correctional facilities	Selected health and social outcomes: society as a whole
Develop personal skills	Offer chronic disease management, family planning, violence prevention, harm reduction, peer education, and other health programmes	Improve diabetes, asthma, HIV outcomes; lower health care costs, better chances for successful re-entry	Improve diabetes, asthma, HIV management; lower health care costs,	Reduced transmission of infectious diseases and [reduced] reliance on health care system for emergency care; improve outcomes for children of inmates
Create supportive environments	Reduce overcrowding; improve sanitary conditions; encourage positive social support; reduce physical and sexual assault and intimidation; provide access to healthy food and opportunities for physical activity; encourage family visits	Reduced transmission of infectious diseases; reduced anxiety and depression; lower violence rates; improved diet; reduced obesity; better family functioning post-release	No overcrowding, lower violence rates and incidences of sexual assaults in jails and prisons; lowered anxiety for corrections staff	Reduced transmission of infectious diseases; lower violence rates, including domestic violence, better outcomes for spouses and children of inmates
Strengthen community action for health	Establish linkages with community organisations, faith-based organisations, and services providers; organise community coalitions to advocate for policies listed above	Increased access to health care and [health] promotion; access to higher-quality health care	Greater infrastructure and resources for providing health care and health promotion; less reliance on funding from corrections departments and time from staff to provide services	Increased social cohesion in high- incarceration communities and as a result and in addition to, less violence and STIs
Reorient health services	Shift from acute episodic treatment to disease management, health promotion, and prevention; develop continuity of care inside and after release; train providers to promote health	Improved control of chronic conditions; lower health care costs after release	Greater infrastructure for providing health care and [health] promotion; lower health care costs; greater efficiency through health promotion	Better community health outcomes; reliance on health care system for emergency care; more seamless medical care inside and on release
Build healthy public policy	Advocate policies that provide substance abuse, mental health, and other services during incarceration and after release; reduce stigma against people returning [to the community] provide job training and education inside and after release	Increased access to and use of substance abuse treatment services, mental health services, increased ability to find employment and reduce dependency after release	Greater infrastructure for substance abuse and mental health treatment and promotion	Lower unemployment rates, illegal activity

Source: Greifinger (2007).

Appendix IV: Best Practice in Continuity of Care for Prisoners on Release

Key features	Strategies
Release planning Each prisoner should have a detailed and individualised plan for release into the community.	Release planning should start from when the prisoner is first admitted into a correctional facility. The first step of release planning is a comprehensive information gathering exercise to access existing health information and assess health needs. This information should be routinely reassessed throughout incarceration. The prisoner should be prepared for release through links to providers in their community of return (see 'linking to community providers'). Prisoners must be provided ongoing assistance to help them access services and support in the community.
Case management Each prisoner should be allocated a case manager to secure and co-ordinate a continuum of services throughout incarceration and on release into the community.	Case management must start before the prisoner is released and continue through transition back to the community. Case managers should provide holistic support. Case managers must be well trained and have a good understanding of programmes and services available in both prisons and in the community. To ensure productive case management and avoid overloading, case managers must be provided appropriate resources and capacity. Case management provides a single point of contact for referrals from professionals.
Linking community providers Linking prisoners to community-based providers in their community of return is absolutely essential for their continuity of care.	Specific appointments with community-based providers should be scheduled so that prisoners can access post-release healthcare. Partnerships between prison-based and community-based health services should be fostered (ie, shared staff, training, a common medical record, well developed referral and outreach protocols and a shared population health perspective). Drop in centres, toll free helplines and telemedicine are useful ways to link prisoners to providers in their community of return.
Holistic approach Continuity of care must not only address health needs, but also the wider determinants of health (ie, criminogenic, psychosocial, and welfare needs).	Release planning should include specific referrals and/or scheduled appointments with health, employment, and housing service providers. In order to mitigate the high risk period immediately post-release, a range of holistic services should be immediately available to prisoners on their release. Continuity of care must address the needs of the individual, their family (ie, assistance for difficult family reunions), and the wider community (ie, encouraging prisoners and their family to engage with their local community). Release plans must address housing needs of soon-to-be released prisoners. On release from prison, every prisoner must at least have temporary secure shelter arranged.

Key features	Strategies
Collaboration between organisations Best practice continuity of care requires collaboration between health, corrections and community-based organisations to address the variety of prisoner needs, support successful re-entry into the community, reduce recidivism, and improve public safety.	High level collaboration and integration of services between Corrections, Health and Justice systems can reduce duplication of services and administration. Community-level collaboration can be fostered through; building new partnerships among service providers to coordinate the provision of services, accurately recording service provision and interactions with prisoners, sharing information, and staff training. Establishing local level coordinating committees can support release planning by; facilitating communication, strategic goal setting, assigning accountability and evaluating progress made. A prisoner health focused conference (or similar event), attended by local stakeholders and providers, can encourage both collaboration and dissemination of ideas. Multidisciplinary teams provide prisoners with comprehensive services and are a common feature of best practice continuity of care.
Prisoner involvement Prisoner involvement in their continuity of care plans encourages 'buy in' to post-release health interventions, and discourages risky behaviour.	Release planning undertaken in partnership with prisoners encourages consideration of special needs relating to cultural identity, language, gender or age when community-based services to support the prisoner on release are arranged. Regular culturally competent communication between the prisoner and a health professional is the first step to health education and provides an opportunity to discuss an individual's health needs. Before release the prisoner should be engaged in a conversation about the meaning and need for continuity of care in the community. Health education can be voluntary or mandatory, be delivered via written or video material, and facilitated in group or individual sessions. Peer-led education programmes can add credibility to health messages, be cost-effective, and provide training and experience for the prisoner educators.
Information transfer The generation of data and effective means of recording and sharing information are essential to best practice continuity of care.	Accurate data about prisoners' health status and health history, and their movement through the criminal justice system should be collected to better understand this population's burden of disease. A standard release document that summarises health information[(a)] should be developed for each prisoner. The release document must be completed prior to release, a hard copy provided to the prisoner on release, and a copy forwarded to any anticipated community providers. Prisoners transferring between correctional facilities should be accompanied by their complete health records. A standardised electronic medical record system, that allows records to be uploaded and updated by either community- or prison-based health providers, should be established.
Continuity of medications and prescriptions Released prisoners must be provided with continuity of medications and prescriptions to ensure that treatment regimes are able to be maintained throughout transition to the community.	An adequate interim supply of medication must be supplied on release. Released prisoners must be linked to a prescriber and dispenser in their community of return.

Key features	Strategies
Research Research into prisoner health supports continuity of care by encouraging informed service delivery, increased knowledge about the prisoner population, and innovation and transparency within prisoner health services.	Outcomes-focused research on continuity of care programmes should be encouraged. The development of a research unit or centre as part of the prison health system and/or collaboration between health, corrections, public health, research groups, and universities would foster research in the area of prisoner health. Specific grants for prisoner health-focused research would encourage New Zealand's research community to better engage in prisoner health issues.

Note: (a) The release document should include at least the following information; pertinent medical history, prior diagnostic studies, physical and laboratory information, allergies, prescribed and non-prescribed medications, scheduled consultations, and follow-up plans for therapy.

Source: Ministry of Health (2007).

References

ABS. 2008. *National Survey of Mental Health and Wellbeing: Summary of results, 2007*. ABS Cat No 4326.0. Canberra: Australian Bureau of Statistics.

ACT Corrective Services. No date. *Operating Philosophy*. www.cs.act.gov.au/home/custodial_operations/operating_philosophy (accessed 1 December 2009).

APA. 1994. *Diagnostic and Statistical Manual of Mental Disorders (DSM IV)*. Washington DC: American Psychiatric Association.

Aos S, Miller M, Drake E. 2006. *Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates*. Olympia: Washington State Institute for Public Policy.

AIHW. 2009. *The Health of Australia's Prisoners*. Canberra: Australian Institute of Health and Welfare. www.gov.au/publications/phe/123/11012.pdf.

Baillargeon J, Binswanger I, Penn J, et al. 2009. Psychiatric disorders and repeat incarcerations: the revolving door. *American Journal of Psychiatry* 166: 103–109.

Binswanger I, Krueger P, Steiner J. 2009. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology and Community Health* 63: 912–919.

Binswanger IA, Stern MF, Deyo RA, et al. 2007. Release from prison: A high risk of death for former inmates. *New England Journal of Medicine* 356(2): 157–165.

Bird SM, Hutchinson SJ. 2003. Male drug related deaths in the fortnight after release from prison: Scotland, 1996–1999. *Addiction* 98(2): 185–190.

Birmingham L et al (2006). Prison Medicine: Ethics and Equivalence. *British Journal of Psychiatry* 188: 4–6.

Borell S. 2010. *Manaaki Whakaora Health Navigator Pilot Programme: Formal evaluation report.* Auckland: Centre for Social and Health Outcomes Research and Evaluation (SHORE) and Whariiki Research Centre, Massey University.

Boyer EM, Nielsen-Thompson NJ, Hill TJ. 2002. A comparison of dental caries and tooth loss for Iowa prisoners with other prison populations and dentate US adults. *Journal of Dental Hygiene* 76: 141–150.

Bradley K. 2009. *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.* London: Department of Health. www.dh.gov.uk.

Braybrook B, Southey P. 1992. *Census of prison inmates 1991*. Policy and Research Division. Wellington: Department of Justice.

Bushnell J, Bakker L. 1997. Substance use disorders among men in prison: a New Zealand study. *Australian and New Zealand Journal of Psychiatry* 31: 577–581.

Butler T, Milner L. 2003. *The 2001 New South Wales Inmate Health Survey*. Sydney: Corrections Health Service.

Canadian Public Health Association. 2004. A health care needs assessment of federal inmates in Canada. *Canadian Journal of Public Health* 95(Supp 1).

Carr J, Tan L. 2009. *Primary Health Care in C&C DHB: Monitoring of Capital & Coast District Health Board's primary care framework – Final report*. Wellington: Capital & Coast District Health Board. www.ccdhb.org.nz/planning/Primary_Care/docs/PCF_Report_2009_Final.pdf (accessed 8 June 10).

Christchurch Health and Development Study [website]. www.chmeds.ac.nz/research/chds

Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients. 1988. *Psychiatric Report*. Wellington: Government Print.

Controller and Auditor-General. 2008. *Mental Health Services for Prisoners: Performance audit report*. Wellington: Office of the Auditor General.

Controller and Auditor-General. 2010. *Performance Audits from 2008: Follow-up report*. Parliamentary Paper B.29(10b). Wellington: Office of the Auditor-General. www.parliament.nz/en-NZ/PB/Presented/Papers/8/2/8/49DBHOH_PAP19683_1-Controller-and-Auditor-General-Tumuaki-o-te-Mana.htm

Correctional Service Canada. 2003. *Specific Guidelines for Methadone Maintenance Treatment.* www.csc-scc.gc.ca/text/pblct/methadone/index-eng.shtml.

Correctional Service Canada. 2004. *Private Family Visiting*. www.csc-scc.gc.ca/text/pblct/visit/index-eng.shtml (accessed 15 March 2010).

Correctional Service Canada. 2007. *Families of Offenders: CSC legislative and policy obligations related to families and visiting*. www.csc-scc.gc.ca/text/fami/legislation-eng.shtml (accessed 15 March 2010).

Correctional Service Canada. 2008. *Quick Fact Sheet.* www.csc-scc.gc.ca/text/pblct/qf/11-eng.shtml.

Costa A. 2008. Health: The first principle of drug policy. *Costas Corner*. www.unodc.org.

Courtney C. 2009. Puppy power. *North and South*, June, no. 279, pp 64–69.

Crampton R. 2007. How do nurses care for prisoner patients? Negative attitudes towards prisoner patients and a range of moral and ethical conflicts can make the caring role difficult for some nurses. *Kai Tiaki: Nursing New Zealand* April 13(3): 32–33.

Crawford M, Rutter D, Manley C, et al. 2002. Systematic review of involving patients in the planning and development of health care. *British Medical Journal* 325: 1263–1265.

Croft J. 2003. *Human Rights and Public Authorities*. A report prepared for the Joint Committee on Human Rights. London: Prison Reform Trust.

DCS Consulting Services Ltd. 2008. Formative evaluation of CADS Offender Project (Auckland Metro). Unpublished.

De Oliveira C, Watt R, Hamer M. 2010. Toothbrushing, inflammation, and risk of cardiovascular disease: results from Scottish Health Survey. *British Medical Journal* 340: c2451. doi:10.1136/bmj.c2451. www.bmj.com/cgi/content/full/340/may27_1/c2451.

De Viggiani N. 2007. Unhealthy prisons: exploring structural determinants of prison health. *Sociology of Health and Illness* 29(1): 115–135.

Department of Corrections. 2003. Output pricing review: review of primary health and disability support services in New Zealand prisons. Unpublished.

Department of Corrections. 2006. Review of Drug Treatment Units. Ministerial briefing.

Department of Corrections. 2007. *Over-representation of Māori in the Criminal Justice System: An explanatory report.* Wellington: Department of Corrections.

Department of Corrections. 2009a. *Annual Report 1 July 2008–30 June 2009*. Wellington: Department of Corrections. www.corrections.govt.nz/news-and-publications/statutory-reports.html.

Department of Corrections. 2009b. *Drug and Alcohol Strategy 2009–2014*. Wellington: Department of Corrections.

Department of Corrections. 2009c. *Māori Focus Units and Māori Therapeutic Programmes Evaluation Report.* Wellington: Policy Strategy and Research Group, Department of Corrections.

Department of Corrections. 2009d. *Pacific Focus Unit – Vaka Fa'aola*. www.corrections.govt.nz (accessed 23 June 2010).

Department of Corrections. 2009e. *Pacific Representation in Corrections*. www.corrections.govt.nz (accessed 23 June 2010).

Department of Corrections. 2010a. Assaults by category 2008/09 financial year. Unpublished.

Department of Corrections. 2010b. *Performance Information for Appropriations: Vote Corrections*. Wellington: Department of Corrections. www.treasury.govt.nz/budget/2010/ise/v7/ise10-v7-pia-corr.pdf.

Department of Corrections. 2010c. *Prison Facts and Statistics: March 2010*. www.corrections.govt.nz/about-us/facts_and_statistics/facts_and_statistics_-_prisons/ps_march_2010.html.

Department of Corrections. No date, a. *Drug Treatment Unit Programme (DTU).* www.corrections.govt.nz/policy-and-legislation/offender-management-manual/Appendix-2-prisoner-programmes-index/area-1-offending-needs-programme-index/drug-treatment-unit-programme-dtu.html (accessed 24 June 2010).

Department of Corrections. No date, b. Offender volumes report: Data worksheets included in this workbook [MS Excel file]. www.corrections.govt.nz/__data/assets/file/0010/395875/prison-sentenced-throughput.xls#DurationAtRelease!a1 (accessed 24 June 2010).

Department of Corrections. No date, c. Prison Health and Disability Support Service Specifications. Unpublished.

Department of Corrections. No date, d. *Prison Service: Policy and procedure manual*. Wellington: Department of Corrections. www.corrections.govt.nz.

Department of Corrections, Ministry of Health. 2004. Memorandum of understanding between the Department of Corrections and the Ministry of Health. Unpublished.

Department of Health. 2002. *Health Promoting Prisons: A shared approach*. London: Crown. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034265.pdf.

Department of Health. 2003. *Healthcare Skills Toolkit*. London: Department of Health and HM Prison Service. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4064367.pdf (accessed 3 June 2010).

Department of Health. 2009. *Improving Health, Supporting Justice: The national delivery plan of the Health and Criminal Justice Programme Board*. London: Department of Health.

Department of Health, HM Prison Service, National Offender Management Service. 2007. *Conference Report: Sharing good practice in prison health*. Department of Health, HM Prison Service, National Offender Management Service. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078070.

Dolan M. 2002. *Neurobiological Approaches to Disorders of Personality.* Liverpool: NHS National Programme on Forensic Mental Health Research and Development.

Donaldson S. 2005. *Time for Your Teeth*. East Sussex, England. www.uclan.ac.uk/health/schools/sphcs/best_practice_awards_2005.php.

Drivers of Crime [website]. www.justice.govt.nz/policy-and-consultation/drivers-of-crime/drivers-of-crime-1/?searchterm=drivers%20of%20crime.

Dunedin Multidisciplinary Health and Development Study [website]. http://dunedinstudy.otago.ac.nz.

Durie M. 2003. *Nga Kāhui Pou: Launching Māori Futures*. Wellington: Huia Publications.

Durie M, Cooper R, Grennell D, et al (Taskforce on Whānau-Centred Initiatives). 2010. *Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives*. www.msd.govt.nz.

Editor. 1996. Promoting health in prisons. *British Medical Journal* 313: 1161.

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. 2001. *Eleventh General Report on the CPT's Activities Covering the Period 1 January to 31 December 2000*. CPT/Inf (2001) 16. Council of Europe. www.cpt.coe.int/en/annual/rep-11.htm.

Families Commission. 2010. *Changing Roles: The pleasures and pressures of being a grandparent in New Zealand*. Wellington: Families Commission.

Fazel S, Bains P, Doll H. 2006. Substance abuse and dependence in prisoners: a systematic review. *Addiction* 101(2): 181–191.

Fazel S, Danesh J. 2002. Serious mental disorder in 23,000 prisoners: a systemic review of 62 surveys. *Lancet* 359: 545–550.

Fazel S, Xenitidis K, Powell J. 2008. The prevalence of intellectual disabilities among 12,000 prisoners: a systematic review. *International Journal of Law and Psychiatry* 31: 369–373.

Finau SA. 1998. *Review of Health Policy for Pacific Inmates*. Unpublished.

Frigon S. 2007. Do women's bodies matter in prison? In MJ Hird, GC Pavlich (eds), *Canadian Sociology for the Asking*. Toronto: Oxford University Press, pp. 239–252.

Glaser W, Florio D. 2004. Beyond specialist programmes: a study of the needs of offenders with intellectual disability requiring psychiatric attention. *Journal of Intellectual Disability Research* 48(6): 591–602.

Gordon L. 2009. *Invisible Children: First year research report 'A study of the children of prisoners' 2009*. Christchurch: PILLARS. www.rethinking.org.nz/images/newsletter%20PDF/Issue%2070/05%20Invisible_children.pdf.

Greifinger R (ed). 2007. *Public Health Behind Bars: From prisons to communities.* New York: Springer Science+Business Media.

Halfon N, Hochstein M. 2002. Life course health development: an integrated framework for developing health, policy, and research. *Milbank Quarterly* 80: 433–479.

Haney C. 2002. *The Psychological Impact of Incarceration: Implications for post-prison adjustment*. Papers prepared for the From Prison to Home Conference, 30–31 January 2002. Washington DC: Urban Institute.

Harpham D. 2010. *Offender Volumes Report 2009*. Wellington: Department of Corrections. www.corrections.govt.nz/__data/assets/pdf_file/0004/402376/offender-volumes-report-2009.pdf.

Hartley A. 1995. Deinstitutionalisation and the criminalisation of the mentally ill. Unpublished (available from Victoria University of Wellington and the Ministry of Justice).

Hartwig C, Stöver H, Weilandt C. 2008. *Report on Tobacco Smoking in Prison*. Final report work package 7, SANCO/2006/C4/02. European Commission. http://ec.europa.eu/health/ph_determinants/life_style/drug/documents/drug_frep2.pdf.

Harwood H. 2008. *Inventory of Cost-Offset Studies for State Substance Abuse Agencies.* Washington DC: National Association of State Alcohol/Drug Abuse Directors. www.nasadad.org.

Hayton P, Boyington J. 2006. Prisons and health reforms in England and Wales. *American Journal of Public Health* 96(10): 1730–1733.

Health Advisory Committee for the Prison Service. 1997. *The Provision of Mental Health Care in Prisons*. London: Prison Service.

Health and Disability Commissioner [website]. www.hdc.org.nz.

Health Professions Networks, Nursing and Midwifery, Human Resources for Health. 2010. *Framework for Action on Interprofessional Education and Collaborative Practice*. Geneva: World Health Organization. www.who.int/hrh/nursing_midwifery/documents/en/index.html.

Health Services Management Centre. 2006. *Prison Health Partnership Survey*. Birmingham, UK: University of Birmingham.

HM Inspectorate of Prisons. 2000. *Unjust Desserts: A thematic review of the treatment and conditions for unsentenced prisoners in England and Wales*. London: Home Office.

HM Inspectorate of Prisons. 2005. *Annual Report of HM Chief Inspector of Prisons for England and Wales: Annual report 2003–2004*. London: The Stationery Office.

HM Inspectorate of Prisons. 2006. *Annual Report of HM Chief Inspector of Prisons for England and Wales 2004–2005*. London: The Stationery Office. www.official-documents.gov.uk/document/hc0506/hc08/0883/0883.asp.

HM Inspectorate of Prisons. 2007. *HM Chief Inspector of Prisons for England and Wales: Annual report 2005/2006*. London: The Stationery Office. www.official-documents.gov.uk/document/hc0607/hc02/0210/0210.asp.

HM Inspectorate of Prisons. 2008. *06/07 HM Chief Inspector of Prisons for England and Wales: Annual report.* London: The Stationery Office. www.official-documents.gov.uk/document/hc0708/hc02/0207/0207.pdf.

HM Inspectorate of Prisons. 2009. *HM Chief Inspector of Prisons for England and Wales: Annual report 2007–08.* London: The Stationery Office. www.official-documents.gov.uk/document/hc0809/hc01/0118/0118.asp.

HM Inspectorate of Prisons. 2010. *HM Chief Inspector of Prisons for England and Wales: Annual report 2008–09.* London. TSO. www.official-documents.gov.uk/document/hc0910/hc03/0323/0323.asp.

HM Prison Service, National Health Service Executive. 1999. The Future Organisation of Prison Health Care: Report by the Joint Prison Service and National Health Service Executive Working Group. London: Department of Health.

HMP Full Sutton, United Kingdom. Delivering quality nurse led health care services. *WHO Health in Prisons Project Best Practice Award 2007*. www.uclan.ac.uk/health/schools/sphcs/best_practice_awards_2007.php.

House JS, Robbins C, Metzner HL. 1982. The association of social relationships and activities with mortality: prospective evidence from the Tecumseh community health study. *American Journal of Epidemiology* 116: 123–140.

Howard League for Penal Reform. 2005. *Prisons are Incapacitated by Overcrowding*. Press release, 11 March.

Human Rights Commission. 2008. *To Be Who I Am: Report of the Inquiry into Discrimination Experienced by Transgender People.* Auckland: Human Rights Commission.

Human Rights Commission. 2009. *Monitoring Places of Detention: Annual report of activities under the Optional Protocol to the Convention against Torture (OPCAT): 1 July 2008 to 30 June 2009*. Auckland: Human Rights Commission.

ICPS. 2004. *Prison Health and Public Health: The integration of prison health services.* Conference report. Kings College, London: International Centre for Prison Studies.

ICPS (International Centre for Prison Studies). 2010a. *Prison Brief for New Zealand.* www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country.php?country=202 (accessed 31 May 2010).

ICPS (International Centre for Prison Studies). 2010b. *World Prison Brief*. www.kcl.ac.uk/depsta/law/research/icps/worldbrief (accessed 29 June 2010).

Indig D, Topp L, Ross B, et al. 2010. *2009 NSW Inmate Health Survey: Key findings report*. Sydney: Justice Health. www.justicehealth.nsw.gov.au/publications/2009_IHS_report.pdf.

It's a jungle in there. 2010. *Sunday*, TVNZ. http://tvnz.co.nz/sunday-news/jungle-in-there-3560722/video?vid=3564666.

James, D. 2006. Court diversion in perspective. *Australian and New Zealand Journal of Psychiatry* 40: 529–538.

James D, Glaze L 2006. *Mental Health Problems of Prison and Jail Inmates*. US: Department of Justice.

Jatrana S, Crampton P. 2009. Primary health care in New Zealand, Who has access? *Health Policy* 93(1): 1–10.

John Howard Society of Alberta. 2001. *Halfway House*. Alberta: John Howard Society of Alberta. www.johnhoward.ab.ca/res-pub.htm.

Joukamaa M. 1998. The mortality of the released Finnish prisoners: a seven-year follow-up study of the WATTU project. *Forensic Science International* 96: 11–19.

Kahui Tautoko Ltd. 2001. *Health Services Review Public Prisons Service*. Wellington: Kahui Tautoko Ltd.

Karaminia A, Butler TG, Corben SP, et al. 2007a. Extreme cause-specific mortality in a cohort of adult prisoners – 1988 to 2002: a data-linkage study. *International Journal of Epidemiology* 36: 310–316.

Karaminia A, Law MG, Butler TG, et al. 2007b. Factors associated with mortality in a cohort of Australian prisoners. *European Journal of Epidemiology* 22(7): 417–428.

Kariminia A, Law MG, Butler TG, et al. 2007c. Suicide risk among recently released prisoners in New South Wales, Australia. *Medical Journal of Australia* 187(7): 387–390.

Klein SR, Bartholomew GS, Bahr SJ. 1999. Family education for adults in correctional settings: a conceptual framework. *International Journal of Offender Therapy and Comparative Criminology* 43: 291–307.

Lash B. 1996. *Census of Prison Inmates 1995*. Wellington: Ministry of Justice.

Lauritsen JL, Sampson RJ, Laub JH. 1991. The link between offending and victimization among adolescents. *Criminology* 29(2): 265–292.

Law Commission. 2009. *Alcohol in Our Lives.* Issues paper 15. Wellington: Law Commission.

Law Commission. 2010. *Controlling and Regulating Drugs*. Issues paper 16. Wellington: Law Commission.

Levenson J. 2002. *Prison Overcrowding: the Inside Story*. London: Prison Reform Trust.

Levy M. 2005. Prisoner health care provision: reflections from Australia. *International Journal of Prisoner Health* 1(1): 56–73.

Manchester, A. 2009. Prison nursing extends skills in a unique primary health setting. *Kai Tiaki: Nursing New Zealand* 15(8): 20–21.

Marshall T, Simpson S, Stevens A. 2000. *Toolkit for Health Care Needs in Prisons.* Birmingham UK: Department of Public Health & Epidemiology, University of Birmingham. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008653 (accessed 24 June 2010).

Marshall T, Simpson S, Stevens A, et al. 2001. Use of health services by prison inmates: comparisons with the community. *Journal of Epidemiology and Community Health* 55: 364–365.

Mason K (chair), et al. 1996*. Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain Mental Health Services*. Christchurch: The Panel.

McLaughlin CP, Kaluzny AD. 2006. *Continuous Quality Improvement in Health Care* (3rd edition). Sudbury, Mass: Jones and Bartlett.

McMurran M. 2002. *Expert Paper: Personality disorders.* Liverpool: NHS National Programme on Forensic Mental Health Research and Development.

Mental Health Commission. 2004. *Seclusion in New Zealand Mental Health Services*. Wellington: Mental Health Commission. www.mhc.govt.nz/Content/Your-Rights/Discrimination-Archives.htm.

Minister of Health. 2005. *Te Tāhuhu: Improving Mental Health 2005–2015*. Wellington: Ministry of Health.

Ministerial Committee on Drug Policy. 2007. *National Drug Policy 2007–2012*. Wellington: Ministry of Health. www.ndp.govt.nz/moh.nsf/indexcm/ndp-committees-mcdp.

Ministerial Review Group. 2009. *Meeting the Challenge: Enhancing sustainability and the patient and consumer experience within the current legislative framework for health and disability services in New Zealand*. Wellington: Ministerial Review Group.

Ministry of Health. 2001. *Services for People with Mental Illness in the Justice System. Framework for Forensic Mental Health Services*. Wellington: Ministry of Health.

Ministry of Health. 2004. *A Portrait of Health: Key results of the 2002/03 New Zealand Health Survey*. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/portrait-of-health.

Ministry of Health. 2005a. Improving the Health of Prisoners. Tau Ke Learning Set, LAMP Top Management Programme May 2005. Unpublished.

Ministry of Health. 2005b. *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan.* Wellington: Ministry of Health.

Ministry of Health. 2006. *Results from the Prisoner Health Survey 2005*. Wellington: Ministry of Health. www.moh.govt.nz.

Ministry of Health. 2007a. *Census of Forensic Mental Health Services 2005*. Wellington: Ministry of Health.

Ministry of Health. 2007b. Health of Offenders Progress Report – August 2007. HR20071520. Unpublished.

Ministry of Health. 2007c. Options for Funding and Delivering Health Services to Offenders. Unpublished.

Ministry of Health. 2007d. *Whānau Ora Health Impact Assessment*. Wellington: Ministry of Health.

Ministry of Health. 2008a. *Health Status of Māori Male Prisoners: Key results of the Prisoner Health Survey 2005.* Wellington: Ministry of Health.

Ministry of Health. 2008b. A *Portrait of Health: Key results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health.

Ministry of Health. 2008c. *Review of Forensic Mental Health Services: Future directions.* Wellington: Ministry of Health.

Ministry of Health. 2009. Review of pilots of mental health and alcohol and other drug services in District and Youth Courts. Unpublished.

Ministry of Health. 2010a. *Review of Forensic Mental Health Services Framework: Future Directions*. Wellington: Ministry of Health.

Ministry of Health. 2010b. *Tuberculosis Case Management in Prisoners: Joint Protocol for Corrections Facilities and TB Treatment Supervising Services (Regional Public Health Services and/or Clinical TB Services) in New Zealand*. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/tuberculosis-case-management-in-prisoners (accessed 18 June 2010).

Ministry of Justice. 2010. *Addressing the Drivers of Crime.* www.justice.govt.nz/policy-and-consultation/drivers-of-crime/drivers-of-crime-1.

Ministry of Social Development. 2009. *Fresh Start and Break-Away Programm*es. www.msd.govt.nz/about-msd-and-our-work/newsroom/media-releases/2009/pr-2009-08-26.html.

Møller L, Stöver H, Jürgens R et al (eds). 2007. *Health in Prisons: A WHO guide to the essentials in prison health*. Denmark: World Health Organization. www.asca.net/documents/e90174-HealthInPris.pdf.

Mumola C, Karberg J. 2006. *Drug use and dependence, state and federal prisoners, 2004*. Special report NCJ 213530. US: Bureau of Justice Statistics. http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=778.

Nadesu A. 2009. *Reconviction Patterns of Released Prisoners: A 60-months follow-up analysis*. Wellington: Department of Corrections.

NASADAD. 2001. *Alcohol and Other Drug Treatment Effectiveness: A review of state outcome studies.* National Association of Alcohol and Drug Abuse Directors. www.nasadad.org/index.php?base_id=90.

National Centre for Lifecourse Research [website]. www.lifecourse.ac.nz.

National Drug and Alcohol Research Centre, University of NSW. 2009. Connections Project evaluation: Final report (internal evaluation). Unpublished.

National Party (T Ryall). 2007. *Better, Sooner, More Convenient.* Health discussion paper. Wellington: National. www.nzdoctor.co.nz/media/136363/bsmc.pdf.

NCAT. 2008. *Investing in Addiction Treatment: A resource for funders, planners, purchasers and policy makers*. Christchurch: National Committee on Addiction Treatment. www.ncat.org.nz/treatment.html (accessed 24 June 2010).

Neuwalt P. 2010. Better, sooner, more convenient primary care: remember the patients! Viewpoint article. *New Zealand Doctor*, June.

New Zealand Association of Occupational Therapists. 2010. Submission on Health and Wellbeing of Prisoners and their Families: An occupational therapy perspective. Unpublished.

New Zealand Police. 2009. *2008/2009 Annual Report*. Wellington: New Zealand Police. https://admin.police.govt.nz/sites/default/files/resources/2009-Annual-Report-Full-Version_e-version1.1.pdf.

NHC. 2007. *Review of Research on the Effects of Imprisonment on the Health of Inmates and their Families*. Wellington: National Health Committee. www.nhc.health.govt.nz/moh.nsf/indexcm/nhc-prisoner-health-research-review-08.

NHC. 2008. Summary of Proceedings from Prisoner Health Workshop. Wellington: National Health Committee. www.nhc.health.govt.nz.

Niveau G. 2007. Relevance and limits of the principle of 'equivalence of care' in prison medicine. *Journal of Medical Ethics* 33: 610–613.

NPREC. 2009. *National Prison Rape Elimination Commission Report*. US: National Prison Rape Elimination Commission. http://nprec.us/publication/report.

Nurse J, Woodcock P, Ormsby J. 2003. Influence of environmental factors on mental health within prisons: focus group study. *British Medical Journal* 327: 480.

Nutbeam D. 2000. Health literacy as a public health goal: a challenge for contemporary health education and communication strategies for the 21st century. Health Promotion International 13: 259–267.

NZDF. 2007. *Reducing Alcohol and Other Drug Problems in New Zealand's Criminal Justice System*. Wellington: New Zealand Drug Foundation.

NZDF. 2010. *New Zealand Drug Foundation submission to Controlling and Regulating Drugs: An Issues Paper on the Review of the Misuse of Drugs Act 1975*. Wellington: New Zealand Drug Foundation. http://nzdf.org.nz/submission/Controlling-and-Regulating-Drugs-Misuse-of-Drugs-Act-Review.

Oakley Browne MA, Wells JE, Scott KM (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

Offender Health. 2007. *Improving Health, Supporting Justice: A consultation*. London: Department of Health.

Offender Health, Social Care, Local Government and Care Partnerships. 2007. *Prison Health Performance Indicators.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079860.

Office of the Auditor-General. 2008. *Performance Audit Report on Mental Health Services for Prisoners.* Wellington: Office of the Auditor-General.

Office of the Inspector of Custodial Services. 2006. *Thematic Review of Offender Health Services*. Perth, WA: Office of the Inspector of Custodial Services.

Office of the Ombudsmen. 2005. *Ombudsmen's Investigation of the Department of Corrections in Relation to the Detention and Treatment of Prisoners*. Wellington: Office of the Ombudsmen, pp 24–25. www.ombudsmen.parliament.nz/index.php?CID=100011.

Office of the Ombudsmen. 2006. *2005/2006 Report of the Ombudsmen Nga Kaitiaki Mana Tangata for the Year Ended 30 June 2006*. Wellington: Office of the Ombudsmen.

Office of the Ombudsmen. 2007a. *Ombudsman's Investigation into the Criminal Justice Sector 2007.* Wellington: Office of the Ombudsman.

Office of the Ombudsmen. 2007b. *Report of Issues Involving the Criminal Justice Sector*. Wellington: Office of the Ombudsmen.

Office of the Ombudsmen. 2007c. *Report of Mel Smith, Ombudsman, Following a Reference by the Prime Minister under Section 13(5) of the Ombudsmen Act 1975 for an Investigation into Issues Involving the Criminal Justice Sector*. Wellington: Office of the Ombudsmen.

Office of the Ombudsmen. 2008. *2007/2008 Report of the Ombudsmen Nga Kaitiaki Mana Tangata for the Year Ended 30 June 2008*. Wellington: Office of the Ombudsmen.

Office of the Ombudsmen. 2009. *2008/2009 Report of the Ombudsmen Nga Kaitiaki Mana Tangata for the Year Ended 30 June 2009*. Wellington: Office of the Ombudsmen.

Office of the Ombudsmen. 2010. *Monitoring Places of Detention.* Wellington: Office of the Ombudsmen. 2009.

Ogden CL, Moffitt TE, Broadbent JM, et al. 2008. Female and male antisocial trajectories: From childhood origins to adult outcomes. Development and Psychopathology 20: 673–716.

Paulin J, Carswell S. 2009. *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative: Interim report*. Wellington: New Zealand Police.

Peer education in collaboration with NGO modus vivendi. Jamioulx Prison, Belgium. *WHO Health in Prisons Project Best Practice Award 2007*. www.uclan.ac.uk/health/schools/sphcs/best_practice_awards_2007.php.

Petersen PE. 2003. *The World Oral Health Report 2003: Continuous improvement of oral health in the 21st century – The approach of the WHO Global Oral Health Programme*. Switzerland: World Health Organization.

Powell J. 2008. The prevalence of intellectual disabilities among 12000 prisoners: a systematic review. *International Journal of Law and Psychiatry* 31: 369–373.

Powell J, Harris F, et al. 2010. Nursing care of prisoners: staff views and experiences. *Journal of Advanced Nursing* 66(6): 1257–1265.

Pratt D, Piper M, Appleby L, et al. 2006. Suicide in recently released prisoners: a population-based cohort study. *Lancet* 368: 119–123.

Prisoners' Aid and Rehabilitation Society. 2007. Submission from Prisoners' Aid and Rehabilitation Society (10 July 2007). Unpublished.

Public Health Advisory Committee. 2005. *A Guide to Health Impact Assessment: A policy tool for New Zealand* (2nd edition). Wellington: National Health Committee.

Public Health Advisory Committee. 2010. *The Best Start in Life: Achieving effective action on child health and wellbeing.* Wellington: Ministry of Health.

Robert D, Frigon S, Belzile R. 2007. Women, the embodiment of health and carceral space. *International Journal of Prisoner Health* 3(3): 178–179.

Robson B, Harris R (eds). 2007. *Hauora: Māori Standards of Health IV. A study of the years 2000–2005.* Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.

Roguski M, Chauvel F. 2009. *The Effects of Imprisonment on Inmates' and their Families' Health and Wellbeing*. Wellington: Litmus Ltd. www.nhc.health.govt.nz.

Roper T, Thompson A. 2004. *Estimating the Cost of Crime in New Zealand in 2003/04.* Working Paper 06/04. Wellington: The Treasury.

Sainsbury Centre for Mental Health. 2009. *All-Stages Diversion: A model for the future*. London: Sainsbury Centre for Mental Health. www.scmh.org.uk/pdfs/all_stages_diversion_model.pdf.

Shaffer JN, Ruback RB. 2002. Violent victimization as a risk factor for violent offending among juveniles. *Juvenile Justice Bulletin*, December. www.ojjdp.ncjrs.org.

Shaw J. 2006. Suicide in recently released prisoners: a population-based cohort study. *Lancet* 368: 119–123.

Simpson AIF, Brinded PMJ, Laidlaw TM, et al. 1999. *The National Study of Psychiatric Morbidity in New Zealand Prisons: An investigation of the prevalence of psychiatric disorders among New Zealand inmates*. Wellington: Department of Corrections.

Simpson AIF, Jones RM, Evans C, et al. 2006. Outcome of patients rehabilitated through a New Zealand forensic psychiatry service: a 7.5 year retrospective study. *Behavioural Sciences and the Law* 24: 833–843.

Sisters Inside (2005) *A Campaign to End the Sexual Assault of Women by the State.* www.sistersinside.com.au/reports.htm (accessed 13 July 2007).

Skipworth J. 2005. Rehabilitation in forensic psychiatry: punishment or treatment? *Journal of Forensic Psychiatry & Psychology* 16(1): 70–84.

Skipworth J, Humberstone V. 2002. Community forensic psychiatry: restoring some sanity to forensic psychiatric rehabilitation. *Acta Psychiatrica Scandinavica* 106(Suppl 412): 47–53.

Skogstad P, Deane FP, Spicer, J. 2006. Social cognitive determinants of help-seeking for mental health problems among prison inmates. *Criminal Behaviour and Mental Health* 16: 43–59.

Slack A, Nana G, Webster M, et al. (2009) *Costs of Harmful Alcohol and Other Drug Use*. Report prepared for the Ministry of Health and Accident Compensation Corporation. Wellington: Business and Economic Research Limited. www.berl.co.nz/874a1.page.

Smith DJ. 2004. *The Links between Victimization and Offending.* Edinburgh Study of Youth Transitions and Crime. Research Digest 4. Old College, Edinburgh: Center for Law and Society, University of Edinburgh. www.law.ed.ac.uk/cls/esytc/findings/digest4.pdf.

Smith DJ, Ecob R. 2007. An investigation into causal links between victimization and offending in adolescents. *British Journal of Sociology* 58: 633–659.

Standards New Zealand. 2008a. *Health and Disability Services (Core) Standards*. NZS 8134.1:2008. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/certification-standards#view.

Standards New Zealand. 2008b. *Health and Disability Services (General) Standard*. NZS 8134.0:2008. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/certification-standards#view.

Standards New Zealand. 2008c. *Health and Disability Services (Infection Prevention and Control) Standards*. NZS 8134.3:2008. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/certification-standards#view.

Standards New Zealand. 2008d. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. NZS 8134.2:2008. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/indexmh/certification-standards#view.

Steenhuisen R, Kalin C (co-chairs, National Committee on Addiction Treatment). 2010. Now's not the time to turn back on addiction treatment. [Opinion] *Dominion Post* www.stuff.co.nz/dominion-post/opinion/3621664.

Stewart LM, Henderson CJ, Hobbs MS, et al. 2004. Risk of death in prisoners after release from jail. *Australian and New Zealand Journal of Public Health* 28(1): 32–36.

Te Whanau o te Waiperiera Trust. 2009. *Whānau First: Whānau tahi, whānau ora – A discussion document on the way forward*. Waitakere City: Te Whānau o te Waiperiera Trust. www.waipareira.com/pdfs/whanaufirstdiscussion-27jul.pdf.

Travis J. 2005. Families and children. Federal Probation 69(1). www.uscourts.gov/FederalCourts/ProbationPretrialServices/FederalProbationJournal/FederalProbationJournal.aspx?doc=/uscourts/FederalCourts/PPS/Fedprob/2005-06/index.html.

United Nations. 1990. *Basic Principles for the Treatment of Prisoners. United Nations General Assembly Resolution 45/111 of 14 December 1990, principle 9*. www2.ohchr.org/english/law/basicprinciples.htm.

van Marle HJC. 2007. Mental health care in prison: How to manage our care. *International Journal of Prisoner Health* 3(2): 115–123.

Verger P, Rotily M, Prudhomme J et al. 2003. High mortality rates among inmates during the year following their discharge from a French prison. *Journal of Forensic Science* 48(3): 614–616.

Ward T, Maruna S. 2007. *Rehabilitation: Beyond the risk paradigm*. London: Routledge.

Warren E, Viney R. 2004. *An Economic Evaluation of the Prison Methadone Programme in New South Wales.* Project Report 22. Sydney: University of Technology Sydney and Centre for Health Economics Research and Evaluation.

Warren F, Preedy-Fayers K, McGauley G, et al. 2003. *Review of Treatments for Severe Personality Disorder*. London: Home Office.

Wesley Community Action. 2009. *The Health of Prisoners Families: A qualitative research project examining the effects that a family member being in prison has on the health of prisoners' families in New Zealand*. Wellington: Wesley Community Action. www.nhc.health.govt.nz.

White P, Whiteford H. 2006. Prisons: mental health institutions of the 21st century? *Medical Journal of Australia* 185(6): 302–303.

Whitehead D. 2006. The health promoting prison (HPP) and its imperative for nursing. *International Journal of Nursing Studies* 43: 123–131.

WHO. 1985. *Health Impact of Low Indoor Temperatures*. Report on a WHO meeting. Copenhagen: World Health Organization.

WHO. 1998. *Report of the Third Meeting of the European Health in Prisons Project, 18–21 November 1998*. The Hague: World Health Organization.

WHO. 2007. *Health in Prisons: A WHO guide to the essentials in prison health.* Denmark: World Health Organization, pp 41–45.

WHO. 2010a. *The Madrid Recommendation: Health protection in prisons as an essential part of public health*. Denmark: World Health Organization. www.euro.who.int/__data/assets/pdf_file/0012/111360/E93574.pdf (accessed 7 June 10).

WHO. 2010b. *Prisons and Health*. World Health Organisation. www.euro.who.int/en/what-we-do/health-topics/health-determinants/prisons-and-health (accessed 24 June 2010).

WHO Europe 1998. Annex I: Consensus statement on mental health promotion in prisons. In: *Mental Health Promotion in Prisons: Report on a WHO meeting*, The Hague, Netherlands, 18–21 November 1998. Copenhagen: World Health Organization.

WHO Europe. 2003. *Prison Health as Part of Public Health. Declaration Moscow, 24 October 2003*. World Health Organization Europe. www.euro.who.int/__data/assets/pdf_file/0007/98971/moscow_declaration_eng04.pdf (accessed 7 June 2010).

WHO Europe. 2010. *Prevention of Acute Drug-Related Mortality in Prison Populations during the Immediate Post-Release Period*. Copenhagen: World Health Organization Europe.

Endnotes

[1] For more information about the New Zealand prisoner population, see section 3.

[2] For more information about this report, see section 1.

[3] This may be an overestimate; personality disorder is difficult to diagnose.

[4] Simpson et al (1999).

[5] Ministry of Health (2006).

[6] As acknowledged in the Government's Addressing the Drivers of Crime work. See Ogden et al (2008) or the National Centre for Lifecourse Research website (www.lifecourse.ac.nz) for local evidence. International studies have found offenders are up to seven times more likely than non-offenders to have been victims. See Smith and Ecob (2007), Lauritsen et al (1991), Smith (2004), Shaffer and Ruback (2002).

[7] Butler and Milner (2003).

[8] See the National Centre for Lifecourse Research website (www.lifecourse.ac.nz) for the most up-to-date evidence. To see how the evidence is being utilised in government policy, see the Drivers of Crime website (www.justice.govt.nz/policy-and-consultation/drivers-of-crime/drivers-of-crime-1/?searchterm=drivers%20of%20crime).

[9] Each time they get caught using drugs again they face punishment, potentially including loss of visiting rights and an extended sentence.

[10] 'The harmful use of alcohol and drugs was estimated recently to have cost the combined Justice sector, that is, police, courts, prison and probation service, $716.5 million in the year 2005/06.' According to the same report, alcohol-related offending consumed $172.2 million, or 18 percent of the police's 2005/06 budget: Slack et al (2009) cited in Law Commission (2009), p 53.

[11] This was a 3 percent rise from the previous year and over a 12 percent rise from 2006/2007: New Zealand Police (2009, p 94).

[12] Most of this cost is associated with treating the victims of violent offences. See Roper and Thompson (2004).

[13] For example, the Rangipo Prison outbreak in 1999.

[14] Gordon (2009), submission to the NHC from the Prisoners Aid and Rehabilitation Society (2007).

[15] See NHC (2007). *Review of Research on the Effects of Imprisonment on the Health of Inmates and their Families*. Wellington: National Health Committee. www.nhc.health.govt.nz/moh.nsf/indexcm/nhc-prisoner-health-research-review-08; Wesley Community Action (2009); Gordon (2009).

[16] Ogden et al (2008).

[17] *Better, Sooner, More Convenient* (National Party (T Ryall) (2007), cited in Neuwalt (2010).

[18] Producing or tending to produce crime or criminality.

[19] For more information about the impact of prisoner health on families and whānau (including children) and communities, see sections 11–13.

[20] Sixty-six young people aged under 17 were in adult prisons in 2008.

[21] NHC (2007).

[22] NHC (2008).

[23] Roguski and Chauvel (2009).

[24] Wesley Community Action (2009).

[25] As at 31 May 2010 and based on an estimated national population of 4.31 million (ICPS 2010a).

[26] New Zealand sits just under Libya in global imprisonment rates. World Prison Brief, ICPS www.kcl.ac.uk/depsta/law/research/icps/worldbrief/ (accessed 29 June 2010). (ICPS 2010b).

[27] Department of Corrections (2007, p 12).

[28] As at 30 June 2009 (Harpham 2010, p 17).

[29] Department of Corrections (2009e).

[30] The 'snap-shot' or daily perspective. See Harpham (2010).

[31] 'Muster' is the term used for a population of prisoners.

[32] As at 30 June 2009 (Harpham 2010, p 63).

[33] Once they arrive in prison. See Department of Corrections (2010c). This figure fluctuates depending on the type of prison.

[34] Harpham (2010).

[35] This is partly because the time they spend as remand prisoners is taken off the time imposed at sentence (Harpham 2010, p 26).

[36] The 'throughput' or yearly perspective. This is less exact but is based on the number of prison sentence 'starts' and 'stops' in a year. See Harpham (2010).

[37] Nadesu (2009, p 6).

[38] The rate for New Zealand European offenders is 47 percent and for Pacific offenders 40 percent (Nadesu 2009, p 9).

[39] Nadesu (2009, p 7). Note that these two statistics are linked, because Māori are much younger as a population group both in prison and in the wider community.

[40] The report largely refers to 'men', and 'women' but some of the people in adult prisons in New Zealand are under 17.

[41] Harpham (2010, p 23). In part, this is because we do not tend to start sending people to adult prison until they are around 20.

[42] Harpham (2010). In 1980, almost 75 percent of sentenced prisoners had recorded their first conviction within the previous 10 years. In 2009, less than 38 percent had recorded their first conviction within the previous 10 years.

[43] 'Life and Preventative Detention ("indeterminate term") offenders are slowly but steadily growing. Through numbers of new starts on indeterminate sentences are low (typically less than 50 per year), they remain in prison for long periods of time and therefore are accumulating to become a significant sub-set (10 percent at last count) of the prisoner population' (Harpham, 2010, p 13). This situation is likely to increase under the new 'three strikes' legislation.

[44] Data obtained from Braybrook and Southey (1992) and Harpham (2010).

[45] Lash (1996), cited in Finau (1998).

[46] 'The proportion of prison sentenced offenders who were female increased from 4% of all prisoners in June 1986, to 5.9% of all prisoners in June 2009. Over this ... period male prison-sentenced offender counts increased by 161 percent from 2359 to 6157 and female prison-sentenced offender counts increased by 297 percent from 98 to 389' (Harpham 2010, p 10).

[47] Harpham (2010).

[48] Gordon (2009, p 4).

[49] Ministry of Health (2006).

[50] Bushnell and Bakker (1997).

[51] Simpson et al (1999, p 57).

[52] Ministry of Health (2006)

[53] Ministry of Health (2008b, p 180).

[54] Simpson et al (1999).

[55] Glaser and Florio (2004).

[56] Binswanger et al (2009).

[57] The study included inmates of jails and prisons. The results for cervical cancer were for only prison inmates. Jails typically hold people awaiting trial or serving short-term sentences and are run by counties and municipalities. Prisons tend to hold individuals serving sentences of a year or more are run by state or federal governments. The health outcomes of the two population groups differed, but do not affect the overall point being made here.

[58] Binswanger et al (2009, p 915).

[59] Halfon and Hochstein (2002, p 433).

[60] See, for example, Ogden et al (2008). Although New Zealand has little evidence in this area, homelessness is common among prison populations internationally.

[61] For some of New Zealand's best research on health and development, see the National Centre for Lifecourse Research website (www.lifecourse.ac.nz/home). Findings from the Dunedin Multidisciplinary Health and Development Study (http://dunedinstudy.otago.ac.nz) and the Christchurch Health and Development Study (www.chmeds.ac.nz/research/chds) are particularly relevant.

[62] Ogden et al (2008).

[63] Such as petty theft, burglary, property damage, and violent or aggressive behaviour.

[64] As does the emergence of some mental health issues (eg, schizophrenia).

[65] Ogden et al (2008).

[66] De Viggiani (2007, p 116). De Viggiani (2007) cites WHO (1998); HM Inspectorate of Prisons (2000); Levenson (2002); Croft (2003, ch 74); Howard League for Penal Reform (2005).

[67] Those who are in prison but have not been sentenced are approximately 20 percent of the New Zealand prison population.

[68] Ministry of Health (2006).

[69] Office of the Ombudsmen (2005, pp 24–25).

[70] Office of the Ombudsmen (2005, p 28).

[71] WHO (1985, p 19).

[72] For example, new prisoners may be housed in police and court cells until a prison bed becomes available.

[73] Roguski and Chauvel (2009, p 17).

[74] Roguski and Chauvel (2009, p 17).

[75] Ministry of Health (2006).

[76] The NHC heard that some health-promoting foods (eg, lemons) are not allowed in prisons because they can be used to create intoxicating substances. Suggestions from prisoners included making healthier food available for purchase and growing their own fruit and vegetables.

[77] Office of the Ombudsmen (2005).

[78] Department of Corrections (2010a).

[79] Roguski and Chauvel (2009, p 16).

[80] Roguski and Chauvel (2009). Prisoners reported that anti-depressant, anti-anxiety, anti-convulsant, and hypertension medications are among those medications believed to compromise clarity of mind, awareness of the environment, and reaction speed. Therefore, they compromise prisoners' ability to cope in a violent and unpredictable prison environment.

[81] Roguski and Chauvel (2009, p 16).

[82] It's a jungle in there (2010).

[83] Wesley Community Action (2009, p 28).

[84] Roguski and Chauvel (2009) p 11.

[85] NPREC (2009, p 127).

[86] NPREC (2009, p 45).

[87] Haney (2002).

[88] Roguski and Chauvel (2009, p 14).

[89] Nurse et al (2003).

[90] Roguski and Chauvel (2009, p 13).

[91] De Viggiani (2007).

[92] Robert et al (2007). The finding is also supported by Frigon (2007).

[93] Sisters Inside (2005).

[94] Frigon (2002, pp 62–64), cited in Roberts et al (2007, p 179).

[95] Roguski and Chauvel (2009, p 8).

[96] Roguski and Chauvel (2009, p 9).

[97] Roguski and Chauvel (2009, p 10).

[98] 'The ways in which Māori values, beliefs, obligations and responsibilities are available to guide whānau in their day-to-day lives' (Durie et al 2010, p 22).

[99] Roguski and Chauvel (2009, p 17).

[100] Skogstad et al (2006).

[101] An at-risk unit enables prison staff to keep prisoners in isolation cells and under continuous observation.

[102] Roguski and Chauvel (2009, p 13).

[103] Staff told the NHC that people could be in an at-risk unit for 'up to a month or more' and for six months.

[104] It was explained to our team that the woman who spent 18 months in the at-risk cell suffered from 'behavioural' problems, which meant the forensic psychiatrists had not deemed her eligible for transfer to the Regional Forensic Unit.

[105] Roguski and Chauvel (2009, p 40).

[106] The American Psychiatric Association in Diagnostic and Statistical Manual of Mental Disorders (DSM IV) defines 'personality disorder' as '[a]n enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the culture of the individual who exhibits it' (APA 1994). Personality disorder is noted on Axis II of DSM IV. There are a range of types and seriousness of personality disorder. Corrections officials believe the number of prisoners who present serious management problems is relatively small, but that these individuals are not adequately treated.

[107] Roguski and Chauvel (2009, p 8).

[108] Roguski and Chauvel (2009, p 11).

[109] Forensic psychiatry is a branch of medicine that focuses on the interface between mental health and the law. The Regional Forensic Psychiatric Service is a health service for people who have a mental illness and/or an intellectual disability within a context of criminal offending.

[110] Steps to Freedom, a re-establishment grant, requires a prisoner to have a bank account (which requires identification) and an appointment with Work and Income New Zealand.

[111] Many prisoners now had family members in the area of the prison as people had moved to be closer to them.

[112] Wesley Community Action (2009, p 67).

[113] White and Whiteford (2006); Kariminia et al (2007c); Pratt et al (2006). See also Bird and Hutchinson (2003). Verger et al (2003) found the risk of death through overdose for post-release inmates to be 124 times higher than for the general population among the group aged 15–34 and 274 times higher for those aged 35–54. See also Joukamaa (1998) and Binswanger et al (2007).

[114] All causes of death included mental, behavioural, and drug-related mortality; cardiovascular disease; cancer; diseases of the digestive, respiratory, endocrine, and nervous systems, and death through accident, suicide, and homicide: Karaminia et al (2007a, p 312).

[115] Karaminia et al (2007a, p 312).

[116] This is particularly true for males. Females are more likely to maintain social support while in prison, particularly as many are the primary caregivers of children before incarceration and many expect to resume these roles on release. Kariminia et al (2007c, p 389) found the risk of death through suicide for women in the post-release period did not increase, but the risk for men rose substantially. They link this to increased social support for women and draw attention to the findings of Klein et al that 'family relationships are an important factor in determining the success or failure of prisoners in adjusting to life after release'.

[117] House et al (1982).

[118] Under the Corrections Act 2004 and Corrections Regulations 2005.

[119] Department of Corrections (no date, c).

120 Forensic psychiatry is the branch of medicine that focuses on the interface between mental health and the law. The Regional Forensic Psychiatric Service is a health service for people who have a mental illness and/or an intellectual disability within a context of criminal offending.

121 Controller and Auditor-General (2010); Office of the Auditor-General (2008).

122 Office of the Ombudsmen (2005, pp 50–58; 2006; 2007c, pp 90–97; 2008, pp 8–9; 2009, pp 9, 14, 32; 2010).

123 Ministry of Health (2005a, 2006, 2008a).

124 Robson and Harris (2007).

125 Human Rights Commission (2008, 2009).

126 NZDF (2007).

127 An Ombudsman may investigate an administrative act, omission, recommendation, or decision without a complaint having been made about that act, omission, recommendation, or decision. This investigation is known as an own-motion investigation (section 13(3) of the Ombudsmen Act 1975).

128 HM Prison Service and National Health Service Executive (1999); Health Advisory Committee for the Prison Service (1997); Niveau (2007).

129 United Nations (1990).

130 For examples, see Roguski and Chauvel (2009).

131 The code is in the Schedule of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

132 Section 3(1).

133 Section 22(1)(b).

134 Section 4.

135 The code is in the Schedule of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. The code is also available from the Health and Disability Commissioner's website (www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full)).

136 For examples, see Roguski and Chauvel (2009).

137 Durie et al (2010, p 22).

138 The principle of Best Whānau Outcomes is about increasing 'whānau capacities to undertake those functions that are necessary for healthy living, and share contributions to the wellbeing of the whānau as a whole, as well as the wellbeing of whānau members' (Durie et al 2010, p 22).

139 For more information, see Durie et al (2010).

140 Aos et al (2006); Harwood (2008).

141 One prison unit manager was said to have informally identified two-thirds of people in his unit as having previously resided in a local, recently closed, mental hospital. In spite of such anecdotal reports from many staff working in the area, researchers have found it difficult to confirm the link. See, for example, Hartley (1995).

142 Skipworth (2005); Simpson et al (2006).

143 An evaluation showed a reduction in the re-conviction rate of about 10–14 percent. There were about 30 percent fewer re-imprisonments among female participants, and positive outcomes for Māori were equal to the benefits for non-Māori: Department of Corrections (2006), cited in Department of Corrections (2009b).

144 Law Commission (2010, pp 342–343).

145 Personal communication, members of the New Zealand Parole Board, 12 April 2010.

146 Harpham (2010).

147 It must be noted that both organisations place significant caveats on this. See for example, the New Zealand Drug Foundation's submission to the Law Commission's review of the Misuse of Drugs Act 1975 (NZDF 2010, pp 5–6).

148 NZDF (2007); Law Commission (2010).

149 Personal communication, Chair of the New Zealand Parole Board, 4 March 2010.

[150] Although there is encouraging work underway to address workforce shortages in this area. For example, the Matua Raki–led dynamic workforce forecasting model for the alcohol and other drug sector.

[151] NCAT (2008, p 1).

[152] Steenhuisen and Kalin (2010).

[153] NZDF (2007); Law Commission (2010).

[154] The police, courts and the Department of Corrections.

[155] NCAT (2008).

[156] John Howard Society of Alberta (2001).

[157] Bradley (2009). See also James (2006).

[158] Sainsbury Centre for Mental Health (2009).

[159] The Intensive Monitoring Group involves case management of 10 young serious offenders with mental health and/or alcohol and other drug issues. These offenders are monitored by the court every fortnight and supported by a team of professionals.

[160] NHC (2008).

[161] Wesley Community Action (2009, p 64).

[162] Ministry of Health (2007c, p 4).

[163] Department of Corrections and Ministry of Health (2004).

[164] Department of Corrections and Ministry of Health (2004).

[165] Department of Health (2002).

[166] WHO (2010b).

[167] Editor (1996); Department of Health (2002); Personal communication, Deputy Director, World Health Organization Collaborating Centre for Health and Prisons, 18 March 2010.

[168] ACT Corrective Services (no date).

[169] Whitehead (2006).

[170] Personal communication, Deputy Director, World Health Organization Collaborating Centre for Health and Prisons, 18 March 2010.

[171] Personal communication, Deputy Director, World Health Organization Collaborating Centre for Health and Prisons, 22 March 2010.

[172] This is a requirement of section 118 of the Building Act 2004, which deals with the need for buildings to meet the requirements of persons with disabilities.

[173] WHO (2010a).

[174] Ministry of Health (2010b)

[175] Personal communication, Health Centre Manager, Waikeria Prison. 16 June 2010.

[176] Personal communication, Deputy Director, World Health Organization Collaborating Centre for Health and Prisons, 13 March 2010.

[177] Nutbeam (2000).

[178] NPREC (2009).

[179] Personal communication, Director of Health and Care, Scottish Prison System, 9 April 2010.

[180] Courtney (2009).

[181] Indig et al (2010, p 143); Personal communication, Director of Health and Care, Scottish Prison System, 9 April 2010.

[182] Roguski and Chauvel (2009, p 40).

[183] Personal communication, Director of Health and Care, Scottish Prison System, 9 April 2010.

[184] Mental Health Commission (2004).

185 NHC spoke with a prison health manager (overseas) who observed that a prisoner who had recently committed suicide had been exhibiting classic signs of suicide risk (eg, giving away precious items) that any staff member in close contact with him should have noticed.

186 Risk points are fixtures or features in a cell that make it easy to commit suicide.

187 Five suicides in 2009 among a muster of about 8,000: Personal communication, Director of Health and Care, Scottish Prison System, 9 April 2010.

188 NHC (2008). See also Crawford et al (2002).

189 NHC (2008).

190 Ministry of Health (2005b, p 2).

191 Peer education in collaboration with non-governmental organisation Modus Vivendi, Jamioulx Prison, Belgium. WHO Health in Prisons Project Best Practice Award 2007. www.uclan.ac.uk/health/schools/sphcs/best_practice_awards_2007.php

192 NHC (2008).

193 Public Health Advisory Committee (2005).

194 Ministry of Health (2007d).

195 Marshall et al (2000).

196 Kahui Tautoko Ltd (2001); Department of Corrections (2003).

197 The Health and Disability Services Standards are NZ 8134.1.1:2008 (core), NZ 8134.1.0:2008 (general), NZ 8134.1.3: 2008 (infection prevention and disease control), and NZ 8134.1.2: 2008 (restraint minimisation and safe practice) (Standards New Zealand 2008a, 2008b, 2008c, 2008d).

198 Ministry of Health (2007b, p 11).

199 Marshall et al (2001).

200 Møller et al (2007, pp 9–10).

201 Roguski and Chauvel (2009).

202 McLaughlin and Kaluzny (2006, p 69).

203 Ministerial Review Group (2009).

204 Personal communication, National Health Manager, Department of Corrections, 4 June 2010.

205 Ministry of Health (2006).

206 Health Professions Networks et al (2010).

207 HMP Full Sutton, United Kingdom. Delivering quality nurse led health care services. WHO Health in Prisons Project Best Practice Award 2007. www.uclan.ac.uk/health/schools/sphcs/best_practice_awards_2007.php.

208 New Zealand Association of Occupational Therapists (2010).

209 One useful tool for workforce planning is the Health care Skills Toolkit, a comprehensive competency based guidance tool for all prison health care staff (Department of Health 2003).

210 Manchester (2009).

211 Personal communication, Health Centre Manager, Christchurch Women's Prison, 14 June 2010.

212 WHO (2007, pp 41–45).

213 See, for example, Crampton (2007).

214 Birmingham et al (2006).

215 Offender Health, Social Care, Local Government and Care Partnerships (2007).

216 To participate in the PHO Performance Programme.

217 WHO Europe (1998).

218 van Marle (2007).

219 Ministry of Health (2001, Appendix 1).

220 One-month prevalence (point prevalence). These figures exclude those with personality disorder and/or substance abuse and dependence alone.

[221] Office of the Ombudsmen (2007b, p 97).

[222] Office of the Inspector of Custodial Services (2006, p 37).

[223] Controller and Auditor General (2010).

[224] Oakley Browne et al (2006).

[225] Ministry of Health (2004)

[226] Controller and Auditor-General (2008).

[227] Ministry of Health (2001, Appendix 1).

[228] Controller and Auditor-General (2008).

[229] Office of the Ombudsmen (2007a, pp 96–97).

[230] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients (1988).

[231] Mason et al (1996, pp 152, 154). The United Kingdom has changed its legislation to explicitly include personality disorder: 'The Mental Health Act 2007 (UK) is more inclusive of all mental disorders and disposes of what was known as the "treatability test". 'While clinical judgement remains paramount in decisions to detain and treat, the Act establishes the principle that personality disorder, as a mental disorder, is now a mainstream condition requiring equal and appropriate consideration for assessment and treatment': Bradley (2009, p 108).

[232] Ministry of Health (2001, p 30).

[233] Ministry of Health (2001, p 30).

[234] Skipworth and Humberstone (2002).

[235] Ministry of Health (2007a, p 52).

[236] Ministry of Health (2008c).

[237] Of the 51 alcohol and other drug reports one alcohol and other drug assessor has provided to the Parole Board, 50 led to a recommendation for alcohol and other drug counselling or residential treatment. However, the board 'ordered' or requested only two of these reports, which the Department of Corrections agreed to pay for. The other 49 reports were requested by the inmate or by their lawyer and were mostly paid for by legal aid.

[238] Stewart et al (2004); Karaminia et al (2007b).

[239] R Brookings, letter to Barry Matthews, Chief Executive, Department of Corrections, 18 June 2009. Brookings argues that Graeme Burton's tragic actions might have been prevented had he had appropriate assessment and long-term residential drug treatment.

[240] Seventy-two percent of inmates served sentences of six months or less between June 30 2008 and June 30 2009. Data derived from Offender Volumes 2009 (Department of Corrections, no date, b).

[241] Nationwide, 10.5 percent of prisoners tested return a positive test. However, this figure is 28 percent in Rimutaka Prison and 38 percent in Mount Eden Prison, which has no drug treatment unit.

[242] The sanctions that may flow from a proven disciplinary charge relate to the loss or postponement of privileges (as defined), the forfeiture of earnings, and cell confinement. Even if no charge is laid, the prisoner may be disqualified from contact visits for a specified period (ie, allowed booth visits only) and have their work placements and temporary release parole reviewed.

[243] The authors of a New South Wales study argue that cessation of methadone maintenance therapy on entry to prison is likely to be associated with poor health outcomes, while the annual cost of in-prison methadone treatment is offset by avoidance of 20 days of incarceration. This would seem to support an economic argument for administering methadone therapy to any qualified prisoner (Warren and Viney 2004).

[244] Ministry of Health (2007b, p 16).

[245] See Harpham (2010, p 25, graph 3.10).

[246] Department of Corrections (no date, a).

[247] This includes the psychosocial component of methadone treatment, also a responsibility of DHBs.

[248] DCS Consulting Services Ltd (2008).

[249] The US National Association of Alcohol and Drug Abuse Directors carried out a meta-analysis of the effectiveness of alcohol and other drug treatment on a range of outcomes, including health and criminal justice involvement. Although the studies the association analysed used different indicators, they all showed that treatment was effective in reducing substance abuse, and that criminal justice involvement dropped in all cases and in some studies decreased dramatically. Decreases in both measures were linked to longer involvement in treatment (NASADAD 2001).

[250] For accounts, see Roguski and Chauvel (2009).

[251] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2001).

[252] This creates an even higher barrier to access for offenders in the community than that facing those in a prison (Ministry of Health 2007b, p 3).

[253] Law Commission (2010); Ministerial Committee on Drug Policy (2007). The overarching goal of the National Drug Policy is to prevent and reduce the health, social, and economic harms that are linked to tobacco, alcohol, and illegal and other drug use.

[254] Ministerial Committee on Drug Policy (2007).

[255] Producing, or tending to produce crime or criminality.

[256] Levy (2005).

[257] Costa (2008) cited in Law Commission (2010).

[258] Ministry of Justice (2010).

[259] Ministry of Social Development (2009).

[260] Petersen (2003, p 3).

[261] De Oliveira et al (2010).

[262] 'Previous dental responsibility' is determined by the dentist, so a prisoner must see the dentist before eligibility is known.

[263] Roguski and Chauvel (2009) p 43

[264] Roguski and Chauvel (2009) p 45

[265] Office of the Ombudsmen (2005, p 58).

[266] Donaldson (2005).

[267] Paulin and Carswell (2009).

[268] One resource is Europe's WHO Health in Prisons Project, due to produce best practice guidelines on prison health needs assessments and prisoner health assessments in 2010–2011.

[269] Personality, coping skills, judgement, memory, the ability to moderate emotion, maintenance of a conventional moral framework, and the ability to assess risks and consequences can be affected. There can be problems with learning, concentration, communication, change, mental health deterioration (ie, depression or anxiety), social disinhibition, impulse control, irritability, and drug and alcohol dependence.

[270] An IQ near to 70 would be 'borderline', although clinicians are aware that no test is so accurate that a resulting IQ score can be taken on face value.

[271] Sections 7 and 8 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

[272] Personal communication, Principal Advisor, Disability Support Services, Ministry of Health, 18 November 2009.

[273] Research by Wesley Community Action found that families sometimes responded to this type of expense by adopting unhealthy strategies such as not eating or not visiting the doctor.

[274] Roguski and Chauvel (2009).

[275] Simpson et al (1999, p 50).

[276] Ministry of Health (2010a).

[277] McMurran (2002); Dolan (2002); Warren et al (2003).

[278] The United Kingdom's National Institute for Health and Clinical Excellence has developed guidelines for the treatment of borderline and antisocial personality disorders.

[279] Bradley (2009) p 108.

[280] From $67 million to $137 million (Department of Corrections 2010b).

[281] Ward and Maruna (2007).

[282] Prisoners' Aid and Rehabilitation Society (2007).

[283] These medications tended to be in the benzodiazepine family.

[284] Personal communication, Director of Health and Care, Scottish Prison System, 9 April 2010.

[285] WHO Europe (2010).

[286] Carr and Tan (2009); Jatrana and Crampton (2009).

[287] Roguski and Chauvel (2009).

[288] Given current arrangements for support on release and the traditionally poor access to health care among this population, 3–4 weeks of medication cover is required rather than the current 4–7 days.

[289] The release document should include at least the following information:; pertinent medical history, prior diagnostic studies, physical and laboratory information, allergies, prescribed and non-prescribed medications, scheduled consultations, and follow-up plans for therapy.

[290] This might mean calling the former prisoner and carrying out or coordinating follow-up that may be required in collaboration with corrections reintegration workers, agencies such as reintegration non-government organisations, Māori or Pacific providers, or disability support providers.

[291] Personal communication, Clinical Manager, West Coast Primary Health Organisation, 14 June 2010.

[292] Interview. Members of non governmental service provider organisations. 2 March 2008.

[293] The groups' terms currently describe their remit in relation to 'health services and exclude corrections non–health-related interventions and activities'. They also forbid 'any decisions which impinge upon the existing policy of either agency'.

[294] Alcohol and other drug assessment and treatment, some mental health care public health, pharmaceuticals, and disability supports are areas in which disagreements remain unresolved or responsibility remains unclear.

[295] Office of the Inspector of Custodial Services (2006, p 15).

[296] Department of Corrections (2009a).

[297] Personal communication, Director, Nursing Directors and Principal Advisor, Queensland Health Offender Health Services, 19 March 2010.

[298] Hayton et al (2006).

[299] Department of Health (2009).

[300] ICPS (2004, p 26).

[301] AIHW (2009).

[302] Department of Health et al (2007).

[303] Department of Health et al (2007).

[304] ICPS (2004, p 26).

[305] Personal communication, Director, Offender Health, Department of Health, 13 April 2010.

[306] Powell et al (2010): 'The move towards a NHS-led primary health care service within prisons, predominantly delivered by nurses, has made positive changes to health care'.

[307] Personal communication, Director, Nursing Directors and Principal Advisor, Queensland Health Offender Health Services, 19 March 2010.

[308] Personal communication, John Boyington, former Director of Prison Health and Director of Health and Offender Partnerships, National Health Service, UK, 23 March 2010. However, the Inspectorate of Prisons (United Kingdom) has sounded a warning that professional isolation and reduced access to training

opportunities can ensue where services are commissioned from prison employees or private providers: HM Inspectorate of Prisons (2009).

309 Personal communication, Director, Nursing Directors and Principal Advisor, Queensland Health Offender Health Services, 19 March 2010.

310 Personal communication, Executive Director, Justice Health, NSW, 9 April 2010.

311 ICPS (2004, p 25).

312 Hayton and Boyington (2006).

313 ICPS (2004, p 27).

314 Personal communication, former Director of Prison Health and Director of Health and Offender Partnerships, National Health Service, UK, 23 March 2010.

315 ICPS (2004).

316 It cited concerns about private sector health provision to prisons and immigrants however, because without accountability in the public sector, these providers did not always conduct health needs assessments for service planning. The office saw the absence of accountability as an invitation to poor practice, poor consistency and less supervision: HM Inspectorate of Prisons (2005, 2006, 2007, 2008, 2009, 2010).

317 Department of Health et al (2007).

318 ICPS (2004).

319 Hayton and Boyington (2006).

320 ICPS (2004).

321 Staff were encouraged to compare patient treatment with how they would like their own children to be treated.

322 Department of Health et al (2007).

323 Department of Health et al (2007).

324 Personal communication, Director, Nursing Directors and Principal Advisor, Queensland Health Offender Health Services, 19 March 2010; Personal communication, Executive Director, Justice Health, NSW, 9 April 2010.

325 Personal communication, Executive Director, Justice Health, NSW, 9 April 2010.

326 Health Services Management Centre (2006).

327 Offender Health (2007, p 30).

328 Department of Health et al (2007).

329 Personal communication, Deputy Director, WHO Collaborating Centre for Health and Prisons, 18 March 2010.

330 Personal communication, former Director of Prison Health and Director of Health and Offender Partnerships, National Health Service, UK, 23 March 2010.

331 Personal communication, Director, Nursing Directors and Principal Advisor, Queensland Health Offender Health Services, 19 March 2010.

332 Personal communication, Director, Nursing Directors and Principal Advisor, Queensland Health Offender Health Services, 19 March 2010.

333 National Drug and Alcohol Research Centre (2009).

334 ICPS (2004).

335 Borell (2010).

336 Personal communication, Director, Nursing Directors and Principal Advisor, Queensland Health Offender Health Services, 19 March 2010.

337 For example, accountability in the health and disability system is ensured through health and disability sector standards, service agreements, and annual plans, and through the Primary Health Organisation performance programme.

338 Each jurisdiction has developed its own model for balancing objectives and maintaining accountability. In one case, the partnership is embodied in a hybrid team model: England and Wales' Director of Offender

Health is accountable to a director general in the Department of Health, but has responsibilities to a director general in the Prison Service as well. The Director of briefs both ministers and has a seat on the National Offender Management Board. The Director's team, which comprises professionals from both agencies, 'has to keep the balance between security and health'.

339 Personal communication, Director, Offender Health, Department of Health, 13 April 2010.

340 Personal communication, Executive Director, Justice Health, NSW, 9 April 2010.

341 Levy (2005).

342 WHO Europe (2003).

343 Office of the Inspector of Custodial Services (2006, p 17).

344 Personal communication, Adviser, Offender Health, Department of Health, 24 July 2007.

345 Office of the Inspector of Custodial Services (2006).

346 Personal communication, Director, Nursing Directors and Principal Advisor, Queensland Health Offender Health Services, 19 March 2010.

347 NHC (2007, p 36).

348 NHC (2007, p 41).

349 Durie (2003).

350 Durie (2003).

351 Travis (2005).

352 Gordon (2009); Wesley Community Action (2009); Roguski and Chauvel (2009).

353 Gordon (2009).

354 NHC (2007, p 36).

355 Gordon (2009, p 46).

356 Wesley Community Action (2009, p xx).

357 Wesley Community Action (2009, p 29).

358 Roguski and Chauvel (2009, p xi).

359 NHC (2007, p 39).

360 Gordon (2009, p 46).

361 Roguski and Chauvel (2009, p 51).

362 Roguski and Chauvel (2009, p 52).

363 Gordon (2009, p 49).

364 Wesley Community Action (2009, p 7).

365 Roguski and Chauvel (2009, p 51).

366 Wesley Community Action (2009, pp 6–7).

367 Gordon (2009, p 47).

368 Wesley Community Action (2009, p 7).

369 Gordon (2009, pp 47–49).

370 Roguski and Chauvel (2009, p viii).

371 Roguski and Chauvel (2009, p ix).

372 Travis (2005).

373 Families Commission (2010, p 11).

374 Families Commission (2010, p 53).

375 Families Commission (2010, p 133).

376 Wesley Community Action (2009, p 8).

377 Correctional Service Canada (2007).

378 Correctional Service Canada (2004).

379 NHC (2007, p 40).

380 Wesley Community Action (2009, p 23).

381 Roguski and Chauvel (2009, p 54).

382 Department of Corrections (no date, d).

383 Wesley Community Action (2009, p 55).

384 Wesley Community Action (2009, p 8).

385 Department of Corrections (2009c).

386 Department of Corrections (2009d).

387 Wesley Community Action (2009, pp 7–8).

388 Gordon (2009).

389 Minister of Health (2005, p 9).

390 Te Whānau o te Waiperiera Trust (2009).