Prison health

A different place for GPs

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BACKGROUND Imprisonment rates in Australia have been steadily increasing over the past decade. Prisoners have high rates of substance use and dependence, mental illness, self harming behaviours and infectious disease.
OBJECTIVE This article discusses health issues of prisoners and the role of general practitioners in prison health.
DISCUSSION The standard of health care provided for prisoners should be equivalent to that available in the general community. Medical officers working within prisons need to be competent GPs with particular skills in managing the unique patterns of morbidity encountered. In addition, public health advocacy, an ability to examine the frequent ethical issues at stake, and close links with colleagues both within prisons and in the community are needed.

The landmark inquiry in New South Wales by Judge Nagle[1] into the prison system in that state re-emphasised the United Nations principle[2] that each prisoner should have the same standard of health care as private citizens. Judge Nagle also stated that the cost of such services should not serve as an excuse for shortfalls in service provision. The basic premise is that the person's health should not be adversely affected by imprisonment.

Arrangements for the provision of health services to prisoners varies from jurisdiction to jurisdiction in Australia. It is generally considered that prison health services are best located (in an organisational sense) outside the correctional agency. This minimises conflicts of interest and maximises the autonomy of the health service (the United Nations' preferred option).

Services are based around a primary care model with registered nurses providing much of the first contact care, supported by medical officers either employed by the health service or visiting on a sessional basis. The work of the medical officer in the prison setting is very similar to that in community based general practice. However, the patient profile and morbidity pattern is different from most general practices, and the environment is obviously different. In addition the health service is responsible for many public health activities. There is also an increasing demand for multidisciplinary case management, working with social workers, clinical psychologists, Aboriginal health workers and Aboriginal liaison officers.

Australian judicial policy

Generally Australian judicial policy, like that of the United States, has moved toward increased utilisation of prisons in an attempt to control crime.[3] Over the 10 years 1991 to 2001, there has been a 24% increase in imprisonment rates for men, and a 66% increase for women.[4] Mandatory minimum sentences plus increased imprisonment of people awaiting trial has increased prison utilisation in the belief that time in prison acts as a deterrent to future criminality.

However, a comprehensive meta-analysis of the scientific literature undertaken in Canada looking at 50 studies since the 1950s, found that prisons, if anything, produce (slight) increases in criminal recidivism.[5] The major determinants of criminal activity lie outside the judicial system and are linked to relative poverty, inequalities of educational and employment opportunity, and family and parenting instability,[6–8] as well as other cultural factors such as availability of firearms, alcohol and drugs.

The authors of the Canadian meta-analysis note that decision makers and the general community change their minds about the appropriateness of sentencing and prison policy when they are

Table 1. Prevalence of health problems and risk factors[11] among prisoners

	Prevalence (%)	
	Female	Male
Hepatitis B, C Ab positive	42	33
Hepatitis C Ab positive	66	33
HIV Ab positive	1.5	0.3
HSV type 2	51	18
Abnormal cervical smear on screening	40	NA
Injury involving being hit by person or object in previous three months	5	11
Alcohol consumption in harmful range	50	50
Past illicit drug consumption	73	64
Past admission into psychiatric hospital	36	34
Beck Depression Inventory (BDI) moderate-high or high score on screening	20	13
BDI suicide high risk on screening	4	2
Previous attempted suicide	39	21

better informed about what alternatives do work – strategies such as noncustodial sentences, recompense to victims and social re-integration.

Morbidity patterns

People in prisons are generally poor, badly educated, physically and mentally disadvantaged, angry and often violent young men.[9] Tomaserski,[10] in a 1992 United Nation's review of prison health, described the main problems in prison health as:

- substance abuse
- mental illness
- communicable diseases, and
- deaths in custody.

Butler's more recent study[11] in New South Wales prisons supported these earlier observations (Table 1). The workload for the medical officer reflects this altered morbidity pattern. Skills in assessing and managing mental illness and substance use and dependence are essential. Rates of mental disorders among prisoners (particularly psychotic and post-traumatic stress disorders) are significantly higher than in the general community.[12] Preventing deaths in custody is the shared responsibility of correctional and health staff. This can be difficult work assessing large numbers of potentially at-risk prisoners and liaising with correctional and specialist psychiatric services, planning ongoing prisoner care and appropriate placement. Mutual respect and confidence in the judgement of members of the multidisciplinary team is essential.

Communicable diseases

Prevention and management of infectious disease is another challenging aspect to prison health. Rates of hepatitis B and C of prisoners on entry into prison are very high.[13] HIV in Australian prisons while not common, is a continuing threat. Cervical intra-epithelial neoplasia should be regarded as an infectious disease, being largely attributable to human papillomavirus infection (extremely common in the female prisoner population).

Substance abuse

There is very little evidence based harm minimisation within prisons. Demand reduction through opioid substitution programs is expanding, using methadone and buprenorphine. This assists those with opioid dependence but with the increased use of amphetamines in the community there is an emerging group of prisoners with substance dependence for whom there is no available substitution treatment. Needle exchange programs have not been introduced into any prisons in Australia despite their use overseas.[14] Reasons behind this reluctance to introduce these programs reflect the ambivalence that exists in the general community. Farrell,[15] commenting on Australian community approaches to preventing hepatitis C infections, stated that there are socio-political taboos that are an Australian tradition going back to 1788: prisoners should not have the same health opportunities as others. However, there are also the very real industrial/occupational health and safety issues for custodial staff. The continuing prohibition of access to sterile needles and syringes ensures that they are secreted in difficult to access places and discarded carelessly if a search is imminent, resulting in an ongoing problem with needlestick injuries among correctional staff. This problem could be safely eliminated through an exchange program.

Indigenous Australians

Aboriginal and Torres Strait Islander people are vastly over represented in Australian prisons. The degree to which this occurs varies between the different states and territories (Table 2). In New South Wales for example, Aboriginal people make up 2% of the general population but 15% of the prisoner population.[16]

There are multiple factors behind this statistic including many of those same social factors that are determinants of poor health such as poverty and low education. Add to this the effects of dispossession, past state sanctioned systems of cultural annihilation and its resultant effects on family supports and cohesion. This over representation of Aboriginal people in prisons presents many clinical and organisational challenges. All jurisdictions have Aboriginal liaison officers. Some are introducing Aboriginal health workers to enhance the

Table 2. Representation of Aboriginal and Torres Strait Islander people in Australian prisons

State/territory	Rate per 100 000 Aboriginal population (2002)	National rate (per 100 000) of incarceration (indigenous and nonindigenous combined)
NSW	1971	140
SA	1652	
VIC	1060	
WA	3036	
TAS	418	
NT	1357	

team of professionals available. Unfortunately rates of imprisonment of Aboriginal people have not fallen over the past 10 years. The only obvious answer to the problem of over representation of Aboriginal people in prison is to imprison fewer of them. That means introducing comprehensive policies to address poverty, substance use, family violence, housing and community development. It also means that the criminal justice system needs to look at expanding noncustodial options for all offenders. This latter would benefit all Australians, not just those in Aboriginal communities.

GPs and nurses

Prison health services are difficult places to recruit experienced general practitioners and registered nurses. The competencies required are those of mainstream clinical practice with particular depth in the clinical areas alluded to above, and include a general knowledge of the criminal justice system, mental health legislation and guardianship related matters. Ethical dilemmas abound so a capacity to examine situations using an ethical framework, as well as a network of colleagues to confer with is essential. Prisons tend to be very isolated institutions and working within this environment runs the risk of assimilating the unique attitudinal norms of the culture, in a noncritical manner. It is remarkable how desensitised one can become to situations that on first encounter seem at best bizarre, at worse grotesque. Close links with 'outside' community based agencies are essential to anchor the clinician's attitudes and professional practice firmly in the societal and professional mainstream. The recent review of the prison health services in the United Kingdom recommended that all medical officers working in Her Majesty's Prisons be vocationally trained in general practice and undergo continuing medical education.[17] Such standards have not yet been recommended in Australia but the logic behind them is obvious.

Conclusion

Prison health services provide primary health care to a group of people with high service needs. The role of the health service in advising correctional services on public health issues is extremely important. The clinical work is demanding but rewarding and requires close collaboration with other health professionals and correctional staff. The more links there are between prison health services and community based health services, including general practice, the higher the standard of care for prisoners will be, and the better the health status of prisoners will be on their eventual release.

Conflict of interest: none declared.

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