



Investigation of the Department of Corrections in relation to the Provision, Access and Availability of Prisoner Health Services

**Chief Ombudsman Beverley Wakem
Ombudsman David McGee**

**Presented to the House of Representatives in accordance
with section 29 of the Ombudsmen Act 1975**

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GLOSSARY OF ABBREVIATIONS AND TERMS

AED	Automated External Defibrillator
AOD	Alcohol and Other Drugs
CADS	Community Alcohol and Drug Services
CPR	Cardiopulmonary Resuscitation
DNR	Do Not Resuscitate
IDU	Identified Drug User
IDU-VC	Identified Drug User Voluntary Check
IOMS	Integrated Offender Management System (the Department's computer system that supports operational delivery)
MedTech	The Department's electronic health records system
MOH	Ministry of Health
NZPB	New Zealand Parole Board
PPM	Policy and Procedure Manual
PSOM	Prison Services Operations Manual
SLA	Service Level Agreement

PRISON REGIONS

Northern Prison Region:

Northern Region Corrections Facility
Auckland Prison
Mt Eden Prison
Mt Eden Corrections Facility
Spring Hill Corrections Facility
Auckland Region Women's Corrections Facility

Central Prison Region:

Waikeria Prison
Hawkes Bay Regional Prison
Manawatu Prison
Whanganui Prison
New Plymouth Prison
Tongariro/Rangipo Prison

Southern Prison Region:

Rimutaka Prison
Arohata Prison
Wellington Prison
Otago Corrections Facility
Christchurch Men's Prison
Christchurch Women's Prison
Rolleston Prison
Invercargill Prison

INTRODUCTION

This own motion report, unlike others we have undertaken, did not arise from specific incidents within the prison system, nor from the number of complaints we receive from prisoners. In fact, health-related complaints we do receive are not overly represented as a source of prisoner complaint. Rather, we considered that Health Services to prisoners are so fundamental to the general welfare of prisoners that they merited examination by the Ombudsmen as part of their general oversight of prison administration. We therefore began from a neutral position not making any assumptions about the Prison Health Service.

Many prisoners come from deprived backgrounds and have had less exposure and access to healthcare than the rest of the population, despite having a significantly higher incidence of mental health and drug and alcohol problems. Thus, we felt it was important, in the public interest, to identify whether or not prisoners receive medical treatment that is reasonably necessary, and whether or not the standard of healthcare provided is reasonably equivalent to the standard of healthcare members of the public could expect.

The main focus of the Department of Corrections is the *"safe and humane containment"* of prisoners. We felt that it was also important to examine how effective the delivery of health services to prisoners is within a restrictive environment where security concerns and risk management, rather than individual health needs, take priority.

The New Zealand prison population is currently approximately 8,000 prisoners. The demands on healthcare in prisons can therefore be considerable. Certainly, our view is that prison nursing has become more complex over recent years with an increase in prisoners with multiple health problems. However, the prison environment can provide opportunities to address the health needs of a particularly vulnerable sector of society, and, for some prisoners, an opportunity to access healthcare which, for a variety of reasons, they have not been able to access previously.

Our investigation has identified that prisoners have reasonable access to Health Services and generally they receive healthcare equivalent to members of the wider community. However, the service is not without its problems and in the future it may not be able to meet the healthcare needs of such a diverse population effectively.

We appreciate the assistance we received from the Department of Corrections in conducting this study, and for the contributions made to our thinking by a range of individuals and organisations with an interest or special expertise in the subject of prisoners' health and human rights in prisons.



Beverley A Wakem CBE
Chief Ombudsman



Dr David McGee, CNZM, QC
Ombudsman

EXECUTIVE SUMMARY

The Department of Corrections is funded to provide a primary healthcare service to prisoners that is reasonably equivalent to that provided to members of the wider community. Services are primarily delivered by departmental nurses with additional services being contracted. Contracted services may include Medical Officers and dentists.

Our investigation has identified that prisoners have reasonable access to the Department's health services and generally they receive healthcare equivalent to members of the public. However, the provision of healthcare to prisoners is not without its problems, and in the future the service may not be able to effectively meet the healthcare needs of the diverse prison population.

The principal opinions that we have formed and the Department's responses (in bold) are:

Chapter 5 - EQUIVALENCE OF CARE

- No external authority requires the external accreditation of prison Health Services. Internal audits of prison Health Services are undertaken, but they are carried out by departmental staff, not an independent regulatory body.

The Department has advised us that a programme, especially designed by the Royal New Zealand College of General Practitioners, began to establish an accreditation process of Health Services in 2011.

Chapter 7 - The DEPARTMENT'S PRIMARY HEALTHCARE SERVICE

(a) Access to Health Services

- There are a variety of methods used in prisons to enable prisoners to access the Department's primary Health Service should they have a health or medical concern. The unrecorded method where prisoners are required to attract the attention of a nurse or ask unit staff to telephone the Health Centre for an appointment is unsatisfactory.

A chit system where prisoners record their name, unit and the reason(s) why they require the services of a Medical Officer or nurse is now used across all prisons. The Department will provide locked boxes for prisoners to submit healthcare requests. Requests will remain confidential until read by Health Services staff.

(iii) Appointment times

- The Department does not record the times that prisoners wait until they are assessed by a Medical Officer. The on-going analysis of demand for Medical Officers' time is necessary if proper assessment of required Medical Officer hours is to be undertaken.

No methodology was used in the past. However, the Department is currently developing a Resource Allocation Model to assist with the appropriate acquisition of Medical Officer and dentist resources.

(v) Health Complaints

- There is no clear distinction on the Department's Integrated Offender Management System (IOMS) between health-related complaints and those that are custodial in nature.

IOMS now has the capability to identify prisoner health-related complaints.

(b) Medication**(ii) The high cost of prescriptions**

- There is a considerable amount of unused medication in prisons which is an unnecessary waste of money for the Department.

The Department recognises that the wastage of medication is unsatisfactory. It is currently working with the Ministry of Health and Regional Forensic Psychiatry Services to identify ways to address this problem.

(iii) Prisoners who self-administer medication

- Some prisoners are permitted to retain a week's supply of medication in their cells. The medication is self-administered (without nurse supervision) at prescribed times during the day. Our investigation has identified that there is an inconsistency of approach across prisons regarding arrangements for prisoners who self-administer their medication.

To ensure a consistency of approach across all prisons, an audit on compliance with policy will be conducted.

(x) Methadone

- The Department's Health Services budget is not ring-fenced. Thus, for example, due to a retraction in the Department's spending, insufficient funds were available to train nurses with regard to the methadone policy.

Unless the Health Services budget is protected, the failure to adequately treat unwell prisoners while they are imprisoned will ultimately place demand on District Health Board Services when they are released back into their communities.

(xiv) Non-clinical time

- The assignment of registered nurses to what often is no more than supervising the swallowing of medication is a poor use of resources.

The Department is considering different models of care in relation to the issuing of medication. The use of Healthcare Assistants in prisons may enable Registered Nurses to spend less time supervising the taking of medication by prisoners.

(c) Treatment

- The treatment of non-serious injuries such as sprains, cuts and grazes appears to be well managed by Health Services staff.

Chapter 8 - EMERGENCY SERVICES

(c) Automated External Defibrillators

- Heart attack is the main cause of premature death in New Zealand. It is surprising, therefore, that custodial staff are not trained to use Automated External Defibrillators.

The Department will provide appropriate training to custodial staff in the use of Automated External Defibrillators.

Chapter 10 - EXTERNAL HEALTH SERVICES

(c) Physiotherapy, Podiatry and other services

- Most prisons are well serviced by external health services.

Chapter 12 - DENTAL AND ORAL HEALTH

- The Department's dental service is not being resourced at a level which reflects the high levels of dental need which exists in New Zealand prisons.

The Department will audit current waiting list times for prisoners to access dental services in order to identify areas of concern.

Chapter 13 - CUSTODIAL SUPPORT FOR HEALTH SERVICES

(c) Transfers

- Seriously unwell prisoners are sometimes transferred from one prison to another. The views of Health Services staff regarding the transfer of prisoners need to be recognised.

Health Centre Managers will now receive a list of those prisoners scheduled for transfer to another prison. Health Services staff will check Medtech to identify any prisoner who is unfit for transfer. Concerns will be conveyed by Health Services staff to the relevant custody officer.

Chapter 14 - HEALTH CENTRE OPERATIONS

(a) General Description of Health Centres

- Prison Health Centres provide the hub of Health Service activities. However, some Health Centres are in need of refurbishment or replacement.

An independent health agency will now assess all Health Centre operations for the effective delivery of Health Services. The Department has given priority to the refurbishment of the Health Centres at Auckland West and Christchurch Men's Prisons.

(e) Procurement of Medical Equipment

- Health Centres are not always resourced with modern and essential equipment to adequately meet the health needs of prisoners.

The Department will ask all Health Centre Managers to audit against the Equipment Policy and Procedures to ensure that the required equipment is in place, or is scheduled (if necessary for purchase through the Capex (Capital Expenditure)) process.

Chapter 16 - PRISONERS WITH MENTAL HEALTH PROBLEMS**(a) General Comment**

- There are deficiencies in the Department's management of mentally unwell prisoners.

We intend to undertake a separate investigation on the identification, management and treatment of mentally unwell prisoners.

(f) The Management of At Risk Prisoners

- The Department did not comment on the management of At Risk Prisoners.

Our view is that the tendency to manage prisoners at risk of self-harm by restricting access to amenities and by isolating them, although necessary in the short term, could contribute to a deterioration of mental state and behaviour in the longer term.

Chapter 19 - THE HEALTH NEEDS OF CERTAIN TYPES OF PRISONERS**(a) Transgender Prisoners**

- The Department said it does not intend to review its current policy regarding the placement of transgender prisoners.

The Department's policy regarding transgender prisoners does not adequately reflect the expectation that transgender prisoners should be treated with dignity, nor does the policy adequately acknowledge prisoners' gender identification.

Chapter 20 - FUTURE OPTIONS FOR THE FUNDING OF HEALTH SERVICES

- Health Services for prisoners should be funded and delivered by an agency whose primary focus is health and therapeutic support, not custodial.

The Department's healthcare funding and delivery of primary Health Services is currently the preferred model. However, this model may not, in the long term, be financially and organisationally sustainable.

Chapter 1 – BACKGROUND

(a) Context

Under section 13 of the Ombudsmen Act 1975, it is the function of the Ombudsmen to investigate complaints relating to matters of administration affecting persons in their personal capacity against various bodies, including the Department of Corrections (the Department). Accordingly, the Ombudsmen have the authority to investigate complaints by prisoners about all aspects of their detention by the Department.

The Ombudsmen provide an independent overview of the investigations of deaths in custody undertaken by Inspectors of Corrections as directed by the Chief Executive of the Department. A significant number of investigations are undertaken each year. From 1 July 2010 until 30 June 2011, 22 deaths in custody occurred. Investigating staff from the Ombudsmen's Office monitored the Department's investigation in respect of every death. This role is undertaken by virtue of a Protocol between the Chief Ombudsman and the Chief Executive.

With the agreement of the Officers of Parliament Committee, we responded to a request to provide a more direct role in prisons in 2007. In a media statement on 25 October 2007, the then Minister of Justice, Hon Mark Burton, said:

"The Ombudsmen are Officers of Parliament, with the highest level of independence within New Zealand's system of government. The designation of clear responsibility for prison-related matters will better ensure that there is an identified independent and impartial entity with responsibility for overseeing and investigating prison complaints and systemic issues."

In addition to investigating complaints, we may make an investigation of our own motion. Our role in undertaking an investigation is to consider the circumstances and form an opinion on the administrative conduct of the Department. If we form an opinion that the conduct was unjust, unreasonable, or wrong, and if we are also of the opinion that steps should be taken in that respect, then we must report our opinion and reasons for it to the Department and may make such recommendations as we think fit.

Under this power, the direct investigation of serious incidents or systemic issues will be undertaken, if it is considered to be appropriate and beneficial.

On 25 June 2009, the Chief Executive of the Department of Corrections was notified of our intention to undertake an own motion investigation of the Department in relation to the provision, access and availability of Health Services for prisoners.

The number of health-related complaints we received during the year ending 30 June 2011 totalled 259. This number of complaints ranked fifth out of the 18 main categories of prison complaint made to the Office. The largest number of complaints received in any one category was 676. Health-related complaints are thus not overly represented as a complaint category, but, nonetheless, we considered the provision, access and availability of Health Services to be important elements in the welfare of prisoners and therefore worthy of investigation.

Our report is a general overview of the Department's Health Services. It does not purport to be an exhaustive coverage of all aspects of the Department's Health Services.

Due to concerns identified during the investigation, present consideration is being given to a separate own motion investigation regarding the Department's management of prisoners with mental illness.

The Department was advised of our preliminary conclusions and proposed recommendations by way of a draft report. In preparing this final report, we took into account the Department's response to the draft. By that stage, various issues discussed in the draft were under review by the Department.

We trust this Report will provide a platform for other improvements in the delivery of Health Services for prisoners.

(b) Prisoner health complaints – The roles of the Ombudsmen, the Health and Disability Commissioner, Health and Disability Advocacy Service and Inspectors of Corrections

Prisoners may request an interview with an Investigator from the Ombudsmen's Office in respect to any aspect of their imprisonment. An Investigator visits each prison in the country approximately once every ten weeks. In addition, prisoners have access to a free telephone number by which they can contact the Ombudsmen's Office direct. Prisoners are, however, expected to have used the Department's Internal Complaints Procedure in the first instance. Nevertheless, where prisoners raise serious health concerns or when there are other reasons for swift action, the Ombudsmen will raise inquiries immediately with the Department.

The Ombudsmen do not usually become involved in prisoner complaints where the underlying issues are related to quality of medical treatment. The resolution of such complaints is regarded as more appropriately being a function of the Health and Disability Commissioner. The Health and Disability Commissioner's statutory role is to promote and protect the rights of consumers and to facilitate the "fair, simple and speedy resolution of complaints about the quality of health and disability services". The jurisdiction of the Health and Disability Commissioner does not prevent the Ombudsmen investigating prisoner health issues, but the Commissioner is a more appropriate initial complaint agency.

From 1 July 2010 until 30 June 2011, the Office received 3,990 complaints from prisoners and on behalf of prisoners. As we have previously mentioned, 259 were health-related complaints. Complaints that were primarily concerned with the conduct or clinical competency of Health Services staff were referred to the Health and Disability Commissioner, while the remaining complaints were resolved directly with the Department.

Pursuant to the Health and Disability Commissioner Act 1994, the position of Director of Health and Disability Services Consumer Advocacy was established. In 1996 a nationwide Health and Disability Advocacy Service was formally established.

The Health and Disability Advocacy Service is available free to any prisoner who has a concern or complaint about a health or disability service. Advocacy is a low-level complaints resolution service, aimed at having the health provider and the consumer resolve their differences directly with each other. The Service is independent of practitioners/providers, government agencies and organisations that fund health and disability services. Prisoners access Health and Disability Advocacy Services by using an 0800 number from prison telephones.

Each prison has a least one advocate assigned to that prison. The Health and Disability Advocacy Service recognises that the prison population is a particularly vulnerable group of people. We were advised that between 1 July 2010 and 30 June 2011, the Health and Disability Advocacy Service received 252 complaints from prisoners.

Advocacy can assist in building better relationships between the health providers and prisoners, so there is improved communication and understanding between the parties, ideally resulting in a better quality health service.

The Department's Inspectors of Corrections, for whom provision is made in the Corrections Act 2004, also investigate complaints from prisoners. Outlined below is the number of health-related complaints investigated by the Inspectorate since 2004.

Year	Complaints
2004/2005	141
2005/2006	167
2006/2007	101
2007/2008	108
2008/2009	139
2009/2010	109
2010/2011	149

Out of the total of 914 complaints from 2004 until 2011, the Inspectorate considered only 6 were justified. The Department considers a justified complaint exists where the agency responsible for the action or outcome being complained of should have acted differently, in that, any of the following conditions apply:

- the action or outcome being complained about did not comply with the applicable legislation or Community Probation Service Operations Manual instructions;
- the action being complained about was not safe, fair or reasonable in the circumstances;
- the action or outcome was not actioned in a timely manner;
- the action being complained about constitutes a breach of the Code of Conduct; or
- some corrective action or redress is warranted.

The Code of Conduct is a set of guidelines for staff that is designed to ensure that the Department's standards are not compromised by inappropriate behaviour that may undermine respect for the Department and its employees.

The number of justified complaints when compared with the total number of health complaints is surprisingly small.

From our experience, many of the prisoner health complaints we receive may be considered "trivial" matters, such as a minor delay in receiving medication from a prison nurse. However, to some prisoners, a matter such as this requires immediate attention. Some prisoners will simultaneously contact this Office and the Department's Inspectorate seeking resolution.

(c) Process

Section 75 of the Corrections Act 2004 states that: *"A prisoner is entitled to receive medical treatment that is reasonably necessary"* and *"the standard of healthcare that is available to prisoners in a prison must be reasonably equivalent to the standard of healthcare available to the public"*.

As a starting point for our investigation, we considered aspects of Primary Healthcare in New Zealand and what *"reasonably equivalent"* care in a custodial setting might be. Given that prisoners are held in a restricted environment, we considered whether the equivalence of care is being achieved in practice.

Our investigation involved the collection of information through direct inquiries of the Department, interviews, and documented sources. The direct inquiries and interviews were conducted on our behalf by an Investigator of this Office who is experienced in prison issues. We identified a number of potential areas of prisoner health that seemed to warrant particular attention. These are discussed individually in the report.

In the course of our investigation we considered:

- relevant legislation;
- international standards and authoritative literature on principles of best health practice;
- previous complaints to the Ombudsmen on health issues; and
- the Department's Policy and Procedure Manual (PPM) and Health Services Manual. (During our investigation the Policy and Procedure Manual was superseded by the Prison Services Operations Manual [PSOM].)

A list of aspects of prisoner Health Services for detailed discussion with the Department was prepared, and for this purpose we drew on the experience of Office of the Ombudsmen staff in dealing with prisoner complaints. We also consulted various outside parties whom we knew to have an interest in prisoners' health and the corrections system.

The prisons visited during our investigation included:

- Auckland Central Remand Prison (On 1 May 2011, Auckland Central Remand Prison was renamed the Mt Eden Corrections Facility. The prison is now managed under contract by global service provision company Serco and is part of Northern Prison Region);
- Auckland Prison;
- Auckland Region Women's Corrections Facility;
- Christchurch Men's Prison;
- Christchurch Women's Prison;
- Hawkes Bay Regional Prison;
- Invercargill Prison;
- Mt Eden Prison (Mt Eden Prison closed in mid-2011);
- New Plymouth Prison;
- Otago Corrections Facility;
- Rimutaka Prison;
- Rolleston Prison;
- Spring Hill Corrections Facility;
- Tongariro/Rangipo Prison;
- Waikeria Prison; and
- Whanganui Prison.

Health issues were discussed with a range of departmental staff on those occasions, and on the occasion of other visits to prisons by staff from our Office.

Health staff interviewed included the National Health Manager, Health Centre Managers, nurses, and Medical Officers. Staff were interviewed on the basis that personal comments and opinions would not be attributed to them, although with the realisation that their comments could be used for the purpose of preparing this report.

During the investigation we interviewed Prison Services staff, including Prison Managers and Corrections Officers of various ranks.

Prisoners in each prison were also interviewed. Their number included male, female, remand, youth, and transgender prisoners. Women prisoners were interviewed at Arohata Prison, Christchurch Women's Prison and Auckland Region Women's Corrections Facility. No general health issues were identified at women's prisons that require special mention. Each prisoner was given an undertaking that he or she would not be identified as the source of any particular information. In total, 50 prisoners were interviewed.

Apart from 5 prisoners at Auckland Prison, whose names were provided by departmental staff for interview, prisoners were chosen on a random basis. We did not inquire into the ethnic background of prisoners and we did not select prisoners for interview on that criterion. However, we are satisfied that a representative range of non-Maori, Maori and Pacific Island prisoners were interviewed.

To place in context the comments made by prisoners, we inspected prison Health Centres and other areas where healthcare and treatment is provided.

We obtained a large quantity of information from the Department in response to numerous written questions that we posed. We record our appreciation for the diligence with which our queries were answered.

As a result of our investigation and the opinions formed, we have decided to make various recommendations.

We record our appreciation for the assistance of Investigator Wayne McIver.

(d) The Ombudsmen's Investigation of the Department of Corrections in relation to the Detention and Treatment of Prisoners 2005

In 2005, the then Chief Ombudsman John Belgrave and Ombudsman Mel Smith presented a report to Parliament titled *"Ombudsmen's Investigation of the Department of Corrections in Relation to the Detention and Treatment of Prisoners"*.

The Ombudsmen found that: *"Prisoners' assessments of the adequacy of medical treatment varied – often according to the health problems of the particular prisoner"*. While some prisoners said that obtaining access to a Medical Officer could involve delay, they assessed the general view of prisoners as being to the effect that medical facilities and treatment were satisfactory.

The Ombudsmen inquired into consistency between prisons. They were told: *"Health Services are organised on a regional basis, with National Office of the Department providing oversight"*.

The Ombudsmen said: *"It appears that Health Service delivery is similar for all prisons, although the architecture does result in some differences. For example, new prisons will have dental facilities, whereas older prisons may not. However, it did appear that there are some problems in recruiting sufficient medical staff which can give rise to regional difficulties"*.

Commenting on dental care, the Ombudsmen observed that: *"A significant number of prisoners are serving sentences of many years. Normal human frailty will inevitably result in most suffering dental deterioration over time as age advances"*.

The Ombudsmen said that the Department appeared to consider both its policy and its delivery of services as satisfactory, and it was correct that the Corrections Regulations for dental care supported the Department's overall approach. Nonetheless, when the Ombudsmen applied the test of whether prisoners are receiving adequate dental care, they regarded the corrections and health systems as failing to provide that standard which should be expected in New Zealand.

A matter which gave the Ombudsmen concern was the lack of 24-hour nursing cover at prisons. This was an issue raised by non-medical staff rather than prisoners.

The Ombudsmen said: *"Having medical staff on-call is not the same as having someone on site. It was evident that front-line staff were very worried about the lack of medically qualified staff in the event of emergency; and emergencies do occur"*.

In their report, the Ombudsmen recommended that the Department:

- (a) *undertakes a full review of the adequacy of dental services; and*
- (b) *establishes 24-hour nursing coverage on site for all prisons, subject to exceptional circumstances.*

Regarding the recommendation that the Department undertake a full review of dental services, our current investigation would suggest that there are major deficiencies in the dental service provided to prisoners. In our view, these deficiencies need to be addressed urgently.

In response to the Ombudsmen's recommendation on 24-hour coverage, the Department said that it *"... provides medical coverage at an equivalent level to that present in the community - 24 hour nursing is not available to the general public"*.

Furthermore, the Department said it was:

"...of the opinion that an increase in the funding for nursing would be better spent on recruiting and retaining day time nursing staff".

We consider the Department's view is not unreasonable. Depending on clinical need, ill or injured prisoners can be escorted to an Accident and Emergency Department. Senior custody staff complained about the frequency of escorts to Accident and Emergency, particularly as this can tax custodial resources. However, it would be unlikely that a prison manager would decline attendance at Accident and Emergency.

(e) Regulatory Requirements

(i) New Zealand Acts and Regulations

Underpinning the Department's Health Services operation are several legislative requirements that apply in relation to prisoners. Health Service staff have legal obligations arising from those requirements.

The Acts and Regulations that are relevant to the Department's Health Service include the Corrections Act 2004, Corrections Regulations 2005, Mental Health (Compulsory Assessment and Treatment) Act 1992, Health Practitioners Competence Assurance Act 2003 and the Privacy Act 1993.

Regulations related to the healthcare of prisoners are contained in regulations 71- 81 of the Corrections Regulations 2005 (**Annex 1**).

(ii) Policy and Procedure Manual (PPM), Prison Services Operations Manual (PSOM) and Health Services Manual

At the beginning of our investigation in June 2009, section B.06 of the Department's PPM contained the policy and performance standards pertaining to prisoner Health Services. The policies set out in PPM B.06 outlined the responsibilities of Health Services and custodial staff in relation to the provision of Health Services for prisoners. It contained policy in regard to medical diets, managing prisoner infectious disease, minimum dental services and the management of unit-dose medication.

In May 2010, PPM was superseded by PSOM. The purpose of the PSOM is: *“to provide instructions to Prison Services employees on the day-to-day activities relating to managing a prison”*.

The development of PSOM was due to a departmental need to reduce duplication, inconsistency and conflict of policy that was contained in PPM.

The transformation of policy from one manual to another did not have a bearing on our investigation. Although PSOM does not now include reference to prisoner health previously found in the PPM, this information is now incorporated into the Health Services Manual. The policies contained in the Health Services Manual have not been amended since the commencement of our investigation.

The Health Services Manual contains an array of topics including clinical practice, human resources, consumer rights and quality improvement. Custodial staff can access the Health Services Manual via the Department's intranet (Corrnet).

This report refers to health policy found in both the former PPM B.06 and the Health Services Manual.

We note that the Department's website contains the PSOM, the Community Probation Manual and the Inmate Employment policy. However the Health Services Manual is not available on the website. In the public interest, the inclusion of the Health Services Manual on the website would be beneficial. This matter has been raised with the Department, but the manual has yet to be posted on the Department's website.

(iii) International obligations

The Department's key international obligations include provisions outlined in:

- United Nations Standard Minimum Rules for the Treatment of Prisoners (UNSMR); This specifies basic standards for prison facilities and the management of prisoners;
- United Nations Optional Protocol to the Convention against Torture (OPCAT) 2002; The provisions have been incorporated in the Crimes of Torture Act 1989;
- International Labour Organisation Convention 29 on Forced Labour (ILO);
- United Nations Convention on the Rights of the Child (UNCROC);
- The International Covenant on Economic, Social and Cultural Rights (ICESCR); and
- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Articles 22-26 of the UNSMR outline the standards that specifically relate to prisoner Health Services (**Annex 2**).

In the Preliminary Observations to the Rules, the United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Geneva in 1955, stated:

“The rules are not intended to describe in detail a model system of penal institutions. They seek only, on the basis of the general consensus of contemporary thought and the essential elements of the most adequate systems of today, to set out what is generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions.”

In terms of the international standards that guide the Department's Health Services, we consider that the Department complies with the principles contained in those rules.

Chapter 2 - PRELIMINARY COMMENT AND OBSERVATIONS

Article 12 of the International Convention on Economic, Social and Cultural Rights (1966) establishes *“the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”*. This applies to prisoners, just as it does to everyone else.

We consider that prison administrators and health professionals have a responsibility to ensure that prisoners receive proper healthcare, and that prison conditions promote the well-being of the prisoners.

There is a basic similarity between healthcare in prison and in the community. For example, prisoners have access to self-care, primary care (first contact care) and secondary care. However, the prison regime governs all aspects of a prisoner’s life (accommodation, diet, exercise, occupation), and has control over many of the factors which affect prisoners’ health. Furthermore, prisons, rather than prisoners, also generate their own institutional needs for health services, such as the need for medical assessments to be carried out on reception, on transfer and prior to prisoners undertaking employment.

In deciding what to do about a health problem, some of the factors a prisoner weighs up are the same as any other a member of the public. How serious is the problem and who can best deal with it? However, other aspects differ. In the first place, many prisoners seem unduly worried about their physical health, and may have exaggerated concerns about the seriousness of the health problem. Secondly, there is limited access to self-help measures such as over-the-counter medication.

The Department is responsible for ensuring all prisoners are accommodated securely, safely and humanely with minimum risk to public and staff safety. In managing prisoners, the Department is responsible for ensuring a prisoner’s basic needs are met, including providing appropriate healthcare, spiritual support and the opportunity for physical exercise. However, prisoners’ assessments of the adequacy of medical treatment varied markedly – often according to the health problems of the particular prisoner.

Providing healthcare in the prison environment poses particular challenges because the primary purposes of the organisation are security and rehabilitation, rather than healthcare. Health Services is a relatively small part of Prison Services operations. In the 2010-2011 year, the Health Services budget was 5% of the overall Prison Services budget. Health Services funding of over \$27m out of a total Department of Corrections budget of \$1b, was only 2.7%.

Custodial staff shortages sometimes impinge on Health Services’ ability to operate effectively. We found that there are often conflicting priorities between custodial staff and those involved with the healthcare of prisoners. This was appositely highlighted when we visited a prison at the same time that the Chief Executive of the Department convened a meeting with custodial staff. All prisoners were locked down in their cells and no health clinics could take place.

Chapter 3 - THE DEPARTMENT'S HEALTH SERVICE

(a) Primary Healthcare, Self-Care and Informal Care

The New Zealand Ministry of Health describes Primary Healthcare in this way:

"Primary healthcare relates to the professional healthcare received in the community, usually from your GP or practice nurse. Primary healthcare covers a broad range of health and preventative services, including health education, counselling, disease prevention and screening".

Formulated at the International Conference on Primary Healthcare 1978, Declaration IV describes Primary Healthcare more fully. It states:

"Primary healthcare is essential healthcare based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which it is a central function and main focus and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing healthcare as close as possible to where people live and work and constitutes the first element of a continuing healthcare process."

Primary Healthcare thus places focus on local primary healthcare services that improve persons' health, keep them well, are easy to access and co-ordinate their ongoing care. Services focus on better health for a population, and actively work to reduce any health inequalities between different groups.

The provision of Primary Healthcare within prisons is the responsibility of the Department. It is funded to provide a primary health service to prisoners reasonably equivalent to that available in the community. The Department has the responsibility of planning, commissioning and providing healthcare for prisoners. This includes primary nursing and medical services. It also provides access to mental health and addiction services, and disability support services.

The Department's Health Service differs from the Primary Health Organisation-delivered Health Service in that it includes the issuing of medication by nurses (akin to a residential institution) and dealing with emergency situations (akin to a hospital's Accident and Emergency Department).

Self-care and informal care are not generally thought of as Health Services, but availability of and access to informal care clearly has an effect on the demand for formal healthcare. In the community most healthcare problems are dealt with through the use of over-the-counter medication or by consulting family members or friends.

However, in practice, prisoners have no alternative except to turn to the primary care service. The result is that primary care in the prison system is over burdened, with more frequent consultation for less important medical conditions than in an equivalent community setting. This can cause significant problems. The prison health system can become overstretched, thereby reducing the time available for the detection of more serious health problems.

Unfortunately there is no local or national data on specific health issues that involve the care and/or treatment by prison healthcare staff. It would therefore be useful for the Department to identify the health needs of the prison population. Health priorities and resource allocation can then be agreed, and a national health plan developed to meet the identified health needs of prisoners.

(b) Secondary and Tertiary Healthcare

Secondary healthcare is the care provided by medical specialists in a hospital. Patients are usually referred from a primary care professional such as a General Practitioner.

Tertiary healthcare includes highly trained specialists and often advanced technology.

The funding for Secondary and Tertiary Health Services for prisoners is the responsibility of District Health Boards. Services for prisoners are accessed by referral from the Department's primary healthcare teams.

District Health Boards are funded by the Ministry of Health to provide all secondary and tertiary level health services to prisoners based on the same eligibility criteria as any other member of the public.

(c) The Organisational Structure of the Department's Health Service

There are seven departmental groups that report to the Chief Executive of the Department of Corrections.

1. Prison Services operate and manage the Department's 19 prisons.
2. Community Probation Services manage community-based sentences and orders, and provide reports for the New Zealand Parole Board.
3. Rehabilitation and Reintegration Services provide for the delivery of rehabilitation and reintegration services.
4. Office of the Chief Executive manages key functions on behalf of the Chief Executive and incorporates Communications, Internal Audit, Inspectorate, Secretariat, Professional Standards Unit and Legal Services.
5. Organisational Development provides strategic advice and day-to-day support and services to the Chief Executive.
6. Strategy Policy and Planning provides specialist and strategic advice to inform decision-making by the Minister of Corrections, the Chief Executive, the Executive Management team and across the Department.
7. Finance, Systems & Infrastructure provides a range of strategies and services that support the delivery of the Department's core business.

Health Services is a division within Prison Services and it reports directly to the General Manager of Prison Services.

The principal health leadership role within Prison Services is held by the National Health Manager. Based at the Department's National Office in Wellington, the National Health Manager is responsible for the department-wide development, co-ordination and maintenance of a Health Services structure. The National Health Manager is tasked with providing nationally consistent offender health policies, processes, projects and programmes.

Also based at the Department's National Office are the Clinical Director, Service Advisor, and Business Analyst. The Clinical Director reports to the National Health Manager and provides advice on clinical policies and procedures and quality assurance. The Service Advisor also reports to the National Health Manager and, among other things, co-ordinates reviews and updates of National Health Services operations. The Business Analyst undertakes analysis of operational performance and provides special project support.

At a regional level (Northern, Central and Southern Prison Regions), Regional Health Managers are responsible for the effective operational management of Health Services. Clinical Quality Assurance Advisors are also regionally based and report to the Clinical Director. They support the Clinical Directors in providing advice in audit activity, risk management, development and maintenance of clinical systems. Clinical Quality Assurance Advisors provide clinical advice to Health Service staff in their regions.

Health Centre Managers are prison-based. They report to a Regional Health Manager and manage one or more prison Health Centres. Health Centre Managers lead prison health teams and are responsible for the effective operational management of Health Services. This includes staff management, budget, service delivery and liaison with relevant external health agencies.

The three prison regions are also divided into area groups. Waikeria Prison, for example, is Area 1 within the Central Region. Because of its size, Waikeria Prison has its own Health Centre Manager. Smaller prisons, such as New Plymouth Prison, have a Team Leader (Health) who reports to a Health Centre Manager. In this case, the Health Centre Manager is based at Whanganui Prison. The Department's view is that the number of prisoners at New Plymouth Prison does not warrant a Health Centre Manager. The healthcare provided to prisoners at New Plymouth is not impeded by having a Team Leader (Health), rather than a Health Centre Manager. Nonetheless, our view is that regardless of the size of a prison, the person responsible for the day-to-day management of health services to prisoners should be afforded the autonomy to do so. For that matter, the Department may want to consider that the person who effectively manages Health Centre operations is afforded the title of Health Services Manager.

The role of Team Leader (Health) is to provide support and practice advice for nurses. Team Leaders (Health) support a team of nurses and report to a Health Centre Manager.

Prison nurses report to either a Team Leader (Health) (as in New Plymouth Prison) or a Health Centre Manager. Their key responsibility is to provide primary healthcare to prisoners, including assessment and treatment within the scope of their nursing practice. In 2010-11, 193 nurses were employed by the Department. The 11 Team Leaders (Health), 15 Health Centre Managers and 3 Clinical Quality Assurance Advisors are also nurses.

Administration Support Staff for nurses are provided at some prisons.

Chapter 4 - THE HEALTH OF PRISONERS

It is generally considered that prisoners, as a group, have poorer physical and mental health than the general community. Previous lifestyles are likely to have put them at risk of ill-health, or have already caused damage.

In 2010, the National Health Committee released its report titled: *“Health in Justice: Improving the health of prisoners and their families and whanau”*. The report said:

“Prisoners have very poor health in comparison with the general population. In their lifetime, more than half of prisoners have experienced a serious mental health condition; 64 percent at least one head injury. Nearly 90 percent have a lifetime prevalence of substance misuse. Many have had infrequent contact with the health system.”

In 2005, the Ministry of Health undertook a survey of prisoners’ health. The survey was undertaken primarily because of a lack of information about many aspects of the health status of prisoners. In summary, the survey found that:

- 31% of male and 45% of female prisoners had a gambling problem at some stage in their lives;
- over half of all prisoners are overweight or obese;
- more than half reported a diagnosis of a chronic condition;
- two thirds of prisoners were smokers;
- almost half of the prison population had experienced tooth pain while eating or drinking in the last month;
- one in three prisoners had a history of one or more of the communicable diseases asked about (these included chlamydia or other STI, scabies and lice, hepatitis B or C, rheumatic fever and tuberculosis); and
- almost two thirds of prisoners had suffered a head injury in their lifetime.

Contemporary health information is important if Health Services is to effectively plan the policies and programmes designed to meet the health needs of prisoners.

Health records are maintained on individual prisoner clinical files, but there is no capability that currently allows the Department to separate this information statistically. We consider that the planning of effective Health Services requires on-going and reliable information on the health needs of the target group. In light of this, we believe the Department could usefully consider the development of a national data collection for prisoners’ health information.

The report of the Review of the Prison Service 1989, commonly called the Roper Report, concluded that the Department’s Health Service failed to meet the health needs of prisoners. The report said this was due to:

- *The fact that prisoners enter the prison environment with existing health problems, often of a chronic nature;*
- *The constraints within the prison environment which undermine good health;*

- *The lack of a co-ordinated prison Health Service in which clearly defined roles and objectives are apparent; and*
- *The isolation of prison Health Services from the mainstream health systems.*

The fact that many prisoners enter the prison system with existing health problems is perhaps a static feature. Regrettably, prisoners will continue to enter the prison system with generally poorer health than individuals in the wider community. This is, of course, something outside the Department's control.

In the 22 years since the Roper Report, improvements to prisoner Health Services have occurred. Notably, there has been established a National Health Manager, a Health Services Manual and a Memorandum of Understanding between the Department and the Ministry of Health. The impetus for positive initiatives, such as those outlined above, should be maintained.

Chapter 5 - EQUIVALENCE OF CARE

Section 75(1) of the Corrections Act 2004 states: *“A prisoner is entitled to receive medical treatment that is reasonably necessary”.*

Section 75 (2) states: *“The standard of healthcare that is available to prisoners in a prison must be reasonably equivalent to the standard of healthcare available to the public”.*

For the purpose of our investigation, we considered incarceration should not present an obstacle to appropriate healthcare.

In a Memorandum of Understanding between the Department and the Ministry of Health dated 2004, public health services are defined as: *“Goods, services, and facilities provided for the purpose of improving, promoting, or protecting population health or preventing population-wide disease, disability, or injury and includes (a) regulatory functions, (b) health protection and health promotion services and (c) goods, services and facilities provided”.*

In the wider sense, we considered *“standard of care”* to include the quality of staff, facilities, equipment and the policies, procedures and practices that govern Health Services work.

Our investigation did not consider the clinical competency of Medical Officers or nurses employed to provide prisoner healthcare. The Nursing Council of New Zealand monitors the continuing competency of nurses, and the Medical Council of New Zealand is responsible for registering and maintaining standards of practice for doctors. Should a prison nurse be dismissed from duty, section 34(3) of the Health Practitioners Competence Assurance Act 2003 requires that: *“An employer must inform the appropriate registration authority if an employee is dismissed for reasons relating to competence”.* In the Corrections setting, this task would be performed by the Chief Executive of the Department.

In the community, the Health and Disability (Safety) Act 2001 establishes a certification regime whereby health and disability services must be certified by the Director-General of Health in order to provide those services. It is an offence under the Act to provide health and disability services without a current certificate.

Since 1 October 2004, all relevant providers of services must be certificated before they can legally deliver health and disability services. Health and disability service providers must demonstrate that their services comply with all relevant approved standards. The standards set out the rights of consumers and ensure service providers are clear about their responsibilities for good outcomes. The 2008 revised Health and Disability Services Standards comprise four sets:

- NZS 8134.0:2008 Health and Disability Services (General) Standards
- NZS 8134.1:2008 Health and Disability Services (Core) Standards
- NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards
- NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standards

The Health and Disability (Safety) Act, however, does not apply to prisons.

Section 8(1) of the Act states:

This Act does not apply to services provided in premises that are -

- (a) a prison within the meaning of section 3(1) of the Corrections Act 2004.

No external authority currently exists that requires the external accreditation of prison Health Services. Internal audits of prison Health Services are undertaken, but they are carried out by departmental staff, and not by an independent regulatory body.

Because there are two agencies (the Department and the Ministry of Health) responsible for prisoner and non-prisoner health, it is difficult to determine with certainty whether healthcare for prisoners fulfils the principle of equivalence. There is no single audit agency that regularly assesses Health Services against standards of healthcare found in the community. Prison Health Services can and do function independently of the wider health community.

To identify whether or not the Department's Health Services provide a "*standard of healthcare*" reasonably equivalent to the standard of healthcare available to the public, assigning responsibility to an independent health audit agency may be something for the Department and the Ministry of Health to consider.

In its response to the Draft Report, the Department has advised us that an accreditation programme, specifically designed by the Royal New Zealand College of General Practitioners, began to establish an accreditation process of Health Services in 2011. This will begin at Tongariro/Rangipo Prison, and then at Whanganui Prison, Auckland Region Women's Prison, Otago Corrections Facility and Christchurch Women's Prison.

We are pleased that the Department has decided to introduce this initiative.

Chapter 6 - SELF-INFLICTED DEATHS IN THE DEPARTMENT'S CUSTODY

Self-inflicted deaths in prison are a most serious concern. Prisoners as a group tend to have a greater propensity to self-harm than the general populace by reason of their background or underlying mental health problems. While hanging is the most common form of self-inflicted death, prisoners have tried to kill themselves using anything from apple stalks to their own fingernails. The Department endeavours to prevent prisoners from self-harming, and staff often successfully interrupt suicide attempts. This is an under-recognised aspect of the Department's work.

The Department told us that departmental staff have intervened 190 times in the past five years in self-harm incidents, where the prisoner would otherwise have been unlikely to survive. Staff are to be commended for their efforts and success. In the context of this investigation, the principal issue is whether failure to deliver appropriate healthcare contributed to suicidal ideation.

Whether self-inflicted, due to natural causes, accident or homicide, any death in custody, as a matter of standard practice, is investigated by an Inspector of Corrections, as directed by the Chief Executive of the Department. The Police separately consider the circumstances of any death.

Individual prisons will additionally also carry out their own internal investigation or operational review regarding the circumstances surrounding the death of a prisoner.

The Ombudsmen monitor every Inspector's death in custody investigation. This means that an investigator will peruse all relevant papers and be present at most, if not all, interviews of witnesses. These may include custodial staff, Health Services staff and prisoners.

After a death in custody investigation has been completed, the Chief Ombudsman will review the Inspector's report. The Chief Ombudsman will express a view to the Chief Executive on whether the Inspector's investigation was carried out thoroughly and fairly, and provide any additional comments that the Chief Ombudsman feels would assist the Chief Executive or the Coroner. An Ombudsman could elect to conduct his or her own independent investigation, but this has never been considered necessary.

Every death of a prisoner is also investigated by a Coroner. The Coroner is a judicial officer whose role is to enquire into the cause of death.

The purpose of the Coroner's Act 2006 is to help prevent deaths and to promote justice through –

- (a) investigations, and the identification of the causes and circumstances, of sudden or unexplained deaths, or deaths in special circumstances; and
- (b) the making of specified recommendations or comments (as defined in section 9 of the Act) that, if drawn to public attention, may reduce the chances of the occurrence of other deaths in circumstances similar to those in which those deaths occurred.

A Coroner's hearing is normally open to the public. After considering all the evidence presented, the Coroner will make a finding as to the cause of death, the circumstances surrounding the death and make any recommendations he/she considers appropriate.

The National Study of Psychiatric Morbidity in New Zealand Prisons, commissioned by the Department in 1997 and published in 1999, found that there are higher rates for many mental disorders and illness, including suicide in prisons, than corresponding rates for the general population.

Examples of the findings include rates of 2-4 percent of prisoners with schizophrenia, 6-11 percent are suffering from depression and around one in five prisoners have frequent suicidal thoughts.

The 1996 report, "Reducing Suicide by Maori Prison Inmates", concluded that the groups most at risk of suicide are remand prisoners, those under the age of 34, and Maori prisoners. Between 1971 and 1995 forty-seven Maori prisoners died from suicide. The Report also found that two-thirds of Maori prisoners who died from suicide did so within six months of being incarcerated. The majority of deaths are by hanging, and occur in the prisoner's cell.

According to the Department's Annual Report 2008-2009, the Inspectorate concluded investigations of 17 deaths in custody investigations in that financial year.

For the most part, Coroners' and Inspectors' death in custody reports concluded that prisoners' health needs were managed in accordance with the standards of care available to the general public. Failings were individual occurrences, and not symptomatic of systemic omission to provide healthcare.

The Department provides a six-week initial training course for new Corrections Officers, which includes a training module on suicide. There is also a two-day Suicide Prevention Awareness Training Programme to help train staff to recognise when a prisoner is showing signs of suicidal ideation or other forms of self-harm.

The training and development of prison staff is important in reducing suicides and other incidents of self-harm in prisons. We would encourage the ongoing training of staff in this area, with regular refresher courses.

The Department has commissioned no new research into mental health in New Zealand prisons since the publication of the National Study of Psychiatric Morbidity in New Zealand Prisons. Unless further or updated research into the prevalence of mental illness in prisons is undertaken, the adequacy or otherwise of current mental health services for prisoners cannot be accurately assessed. We should, however, acknowledge the Controller and Auditor-General's report into "Mental Health Services for Prisoners" published in 2008.

The recommendations made by the Controller and Auditor-General in his report can be found on the website www.oag.govt.nz.

Chapter 7 - THE DEPARTMENT'S PRIMARY HEALTHCARE SERVICE

(a) Access to Health Services

(i) Making a request to Health Services

The manner in which prisoners access Health Services is fundamentally important to satisfactory healthcare. Many prisoners are marginalised individuals who may not have accessed healthcare in the community. Custody, perhaps for the first time, provides an opportunity to address unmet health needs. Making a request to Health Services should take into account any learning difficulties of prisoners and cultural and language diversity.

Prisoner access to Health Services is discussed in the Department's Health Services Manual. The policy states "that all Health Centres must have a process in place for assessing and actioning in-coming health referrals".

Each prison we visited had a method by which prisoners access Health Services. However, the methods differed, and varied in their effectiveness.

At the prisons we visited, prisoners access Health Services by variously:

1. attracting the attention of a nurse when he/she is in the unit;
2. asking unit staff to telephone Health Services to make an appointment;
3. asking unit staff to place the prisoner's name on a whiteboard;
4. completing a simple health "chit" or request form and handing it to unit staff. The form is then placed on a clipboard and placed in the unit guardroom;
5. completing a request form and placing it in a Health Services mail box. Mail boxes are locked and only Health Centre staff have keys; or
6. completing a request form, placing the request in an envelope and mailing it through the prison mail system. Administration staff capture request forms as part of their normal duties and forward them to Health Services staff.

Almost all of the procedures used have some merit. However, we consider the single process whereby prisoners are required to attract the attention of a nurse or ask unit staff to telephone the Health Centre for an appointment, is unsatisfactory. A more formalised process is required.

A prisoner complained to our Investigator that: *"Prisoners have to catch the eye of a nurse who is passing through before they are seen"*. He claimed: *"I kept wanting to see the nurse but she kept walking past"*.

Providing prisoners with a high level of access to Health Services and minimising barriers to access by removing formality are to be encouraged. However, these two approaches seem to us to be somewhat "hit and miss", in that there is no proper record-keeping for requests. We consider requests for assistance from Health Services should be more systematic.

Writing prisoners' names on a whiteboard to see a nurse is a simple method, but it raises issues of privacy. It is also a very temporary method of recording and easily open to mistaken deletion.

At some prisons, prisoners are required to complete a request form and hand it to custodial staff to be placed on a clipboard. This approach again raises a question regarding the confidentiality of the information disclosed. Also, the procedure is dependent on the reliability of unit staff to ensure that request forms are actually placed on clipboards. A Senior Corrections Officer told us that request forms did sometimes go missing. In one instance, a request form was placed in an officer's pocket, taken home and washed with the family's washing. While probably not a common occurrence, it should not have occurred at all.

Confidentiality for prisoners is emphasised in section 4 of "A Human Rights Approach to Prison Management-Handbook for Prison Staff" 2002. It states:

"The right to confidentiality also requires that prisoners should not have to submit their requests for access to the doctor to other prison staff. Under no circumstances should they be required to disclose their reasons for seeking a consultation. The arrangements for seeking a medical consultation should be made clear to prisoners on admission to the prison."

Prisoners complained that when they had informally approached a nurse to seek assistance or advice for an otherwise minor injury or complaint, they were asked to fill out a request form. In these instances, they said the nurse could have easily addressed their health concerns without the need to complete a request form. Certainly in units that hold prisoners with a lower security status, less reliance on request forms could be considered. In lower security units, regimes are less restrictive and prisoners generally pose less of a physical risk to staff. However, this process is also rather "hit and miss". Nurses could unwittingly fail to record the nature of the prisoner's health concern on prison records. There is essentially nothing wrong with informal approaches if prisoners are comfortable using them. However, they need to be underpinned by a standard and reliable method.

In our view, it is unreasonable if the effect of prisons' administrative processes results in the unnecessary disclosure of prisoner health information. The most effective process we identified was the completion of a health request form which was then placed in a locked mailbox. Only Health Services staff have keys to access the request forms inside. A Health Centre Manager suggested that more information tends to be provided by prisoners on health 'chits' placed in a box. This, she said, is due to requests for Health Services not being viewed by custodial staff.

It was unclear at some sites whether or not, after submitting a health request, prisoners were advised about how and when they would actually see the nurse or a Medical Officer. When a request is made, the form is subsequently placed on the prisoner's health file. However, there appears to be no system of recording that the prisoner had been informed of when his/her appointment would be scheduled. We consider this is an important step, as some health needs will be more urgent than others, and a prisoner may need an opportunity to request greater priority.

That said, we consider prisoners' access to healthcare is generally good and that prisoners, in the main, have swift access to primary care services.

We recommend that the Department:

- 1. Develop a standard health request process. One option may be the provision of a locked box for request forms; and**
- 2. Provide prisoners with written acknowledgement that their request has been received, and, if possible, advise when action is intended.**

In its response to the Draft Report, the Department said:

"The Healthcare Pathway and Procedures Policy (Section 6: Incoming Referrals to Health Centres) describes the process for prisoners to access health services. The policy is currently being revised and is due for completion in June 2011. The revised policy contains greater expectations around the process and it is expected that this will result in all sites having an effective and confidential process for prisoners to request health services. An audit of each site will be carried out in due course to ensure that appropriate systems are in place.

The revised Healthcare Pathway and Procedures Policy (see Recommendation 1 above) includes a requirement for Health Centres to include 'who acknowledges the referral to the prisoner or Custodial staff member'. This requirement will be considered as part of an audit on all sites compliance with health service policies."

(ii) Health Services screening procedure

In the general community, when people require the services of a health professional in a primary care setting, the usual practice is to make an appointment with their local General Practitioner. In a prison setting, the standard process requires that prisoners are initially seen by a nurse. A clinical assessment will be undertaken to determine what care or treatment can be appropriately provided by nursing staff, or whether the prisoner's health concern should be referred to a Medical Officer i.e. a doctor (see Chapter 11 - Contracted Medical Officers).

The screening procedure, or triage as it was called by Health Services staff, allows a prisoner's health need(s) to be ranked in terms of importance or priority and ensures that a Medical Officer's time is not consumed by trivial matters. Prisoners, unlike members of the general public, cannot self-medicate by visiting a pharmacist and are reliant on the health professionals within prisons.

In questions put to the Department regarding Health Services for prisoners, we were assured that registered nurses have the skills required to enable them to make appropriate screening decisions. In particular, we were told that nurses are required to attend a Pre-Hospital Emergency Care training course. This is a three-day course that covers skills and knowledge for people involved in the advanced first aid/pre-hospital care environment.

We note from the Department's recruitment website that individuals applying for prison nursing positions should have, among other things: *"recent clinical experience in primary or secondary healthcare nursing, a broad range of post-graduate clinical experience and experience in triage (desirable)"*.

Health Services' screening of prisoners by nurses seems appropriate if medical resources are to be prioritised effectively. However, we consider that the Department should ensure that all nurses engaged in such work are fully and appropriately trained, and receive refresher courses on a regular basis.

(iii) Appointment times

Based on clinical assessment, prisoners whose health needs cannot be met by nurses are placed on an appointment list to see the prison's Medical Officer.

The number of prisoners on appointment lists varies across the country's prisons. At some prisons, prisoners see the Medical Officer at the next available appointment; at others the wait is 3-4 days or even up to 2 weeks.

At one prison we visited, due to the limited number of hours the Medical Officer is contracted to work, prisoners with an appointed time to see the Medical Officer are sometimes not seen due to over-ambitious scheduling. There is insufficient time available to see all prisoners at the appointed times.

At the foregoing prison, assessments are prioritised according to clinical need, and the Department advises us that any prisoner who is taken off an appointment list is re-listed on the next Medical Officer's attendance. However, it would appear that demand for Medical Officer services is generally not being met at this prison.

In the Ombudsmen's own motion investigation, *"In relation to the Detention and Treatment of Prisoners"* in 2005, the Ombudsmen reported that a problem perceived by some prisoners is that nurses "prevent" them from seeing a Medical Officer. However, the Ombudsmen at that time found no basis to conclude that nurses were inappropriately "preventing" prisoners consulting a Medical Officer.

During our current investigation, prisoners again complained about this. In many instances, prisoners told us that getting to see the Medical Officer is solely dependent on the type of relationship they had established with nursing staff. Some prisoners believed that they were getting "bumped off" the appointment list as a result of them not getting along with nurses.

In most cases, if a prisoner requests to see a doctor, this would be arranged, although the prisoner would be placed on a clinical priority list.

We asked the Department how many hours Medical Officers are contracted to work at each prison. The figures we received reveal that at a prison with 666 prisoners, the Medical Officer is contracted to work 4 hours per week.

By contrast, at another prison, the Medical Officer is contracted to work for 3 hours per week with a prison muster of 112 prisoners. Another prison has the benefit of a Medical Officer being on site for 20 hours per week for a prison population of 280 prisoners.

We asked the Department what formula or calculation is used to determine the numbers of hours Medical Officers should be contracted to work at each prison.

The Department's response was that:

*"Historical trends have enabled health centres to determine the number of hours
Medical Officer clinics are required to run at each health centre."*

We were not provided with a specific calculation formula.

Our understanding is that the Department does not record the times prisoners wait until they are assessed by a Medical Officer. We consider that the ongoing analysis of demand for Medical Officers' time is necessary if proper assessment of required Medical Officer hours is to be undertaken.

We recommend that the Department devise a method by which appointment time data can be regularly collected and analysed for the purpose of assessing required Medical Officer hours.

In its response to the Draft Report, the Department said:

"The Department will establish a process for monitoring and reporting on Medical Officer appointment time data."

(iv) Health information

Upon their entry to prison, prisoners undergo an induction process to familiarise themselves with the prison environment.

The Department said that health information for new prisoners is available on computerised information kiosks in those prisons where kiosks are installed. Kiosks provide a visual display of information for prisoners. That includes, apart from health information, general information regarding the Corrections Act 2004 and Corrections Regulations 2005.

A recent survey of working kiosks shows that many have been vandalised or have broken down. We are told that the Department's policy in the Northern Region is that damaged kiosks will not be repaired. We have separately revisited the issue of the availability of working kiosks with the Department.

We appreciate that the cost to repair kiosks is likely to be expensive. However, it is important that prisoners have access to readily available health information. In the event that kiosks are not operational, we consider that the Department should make available site-specific health information in hard-copy form to prisoners.

(v) Health complaints

The Department's complaints process allows a prisoner, or other person acting in the interests of a prisoner, to raise any issue the prisoner wishes to have investigated or reviewed.

On being advised of a prisoner's complaint, unit staff attempt to resolve the prisoner's concern(s) informally before the prisoner lodges a formal (i.e. written) complaint. If a prisoner's concerns cannot be resolved at an informal level, the prisoner is given a complaint form to complete. The form handed to unit staff initiates a formalised process aimed at resolving the prisoner's complaint.

An interviewing officer, usually a Principal Corrections Officer, will then interview the prisoner. This should normally occur within 3 days of receipt of the complaint. Prisoner complaints can be escalated to unit manager or prison manager level.

Our view is that prisoners should not have to discuss confidential health matters with custodial staff. All health-related complaints should be forwarded directly to the Health Centre Manager. There should also be a clear distinction on the Department's Integrated Offender Management System (IOMS) between health-related complaints and those that are custodial in nature. The separation of health complaints from custodial complaints would make for a more rapid response to the management of prisoners' health complaints.

We recommend that all prisoner health-related complaints be forwarded directly to the Health Centre Manager and that the Department institutes a specific health complaints function on IOMS.

In its response to the Draft Report, the Department said:

"There is a national policy and procedure for all prisoner complaints (where complaints are recorded on the PC.01.Form 01 Prisoner Complaint Form). All health-related complaints are referred to the Health Centre Manager (or delegate) and are recorded electronically (even if received verbally). Complaints are recorded in IOMS. The Complaint Policy and Procedures policy (last updated 27 May 2010) describes the process for managing prisoner health related complaints."

We inquired further of the Department regarding the management of prisoner health complaints. The Health Services Manual, as the title suggests, is primarily used by Health Services staff and it outlines the process involved when prisoners submit health-related complaints. However, there is no specific reference to this in the Prison Service Operations Manual (PSOM).

The purpose of PSOM *"is to provide instruction, primarily to custodial staff, on the day-to-day activities relating to managing a prison."* Custodial staff are more likely, in the first instance, to receive health-related complaints than Health Services staff. As such, we consider that there should be a specific reference to health-related complaints in PSOM. We asked that an additional note be added to the PSOM policy around prisoner complaints that would ensure that any health related complaints are directed to Health Services for a response. This has now been included in the Department's policy as set out below:

"If the prisoner complaint relates to Health Services or health staff, the complaint must be forwarded to the Health Centre Manager once:

- the prisoner has completed PC.01 Form.01 Prisoner Complaint, and;*
- the PCO has completed the receipt section of the form."*

(b) Medication

(i) Non-prescription pain relief

The Department advised us that the only type of non-prescription pain relief offered to prisoners by custodial staff is paracetamol. Paracetamol is considered an "over-the-counter" medication, and as such it is a commonly available product given to prisoners without the need for a Medical Officer's prescription.

Paracetamol is considered to provide effective temporary relief of pain and discomfort associated with headaches, cold and flu symptoms. Health Services staff told us that paracetamol has few (if any) side effects, providing the correct daily dose is adhered to.

The Department's policy states that if a prisoner has acute toothache, Health Services staff may direct that paracetamol be issued with a further dose available to the prisoner to self-administer during the night.

Although we are advised that paracetamol is an effective and safe product, pain associated with stomach ache, toothache, sore throat and earache may require stronger pain relief.

We were told by prisoners that they are frequently advised by custody staff, *"to take paracetamol and lie down"* or *"paracetamol will fix everything"*. Many prisoners told us that paracetamol does not relieve the level of pain they experience.

It appeared to us that there are few problems with custodial staff issuing paracetamol but rather, as many prisoners claimed, it may not provide sufficient relief of pain and discomfort.

Comments by departmental staff, however, would suggest that they consider paracetamol is given to prisoners too frequently. A Team Leader (Health) said: *"Too much is used and it is not always recorded"*. Similarly, a prison Chaplain said: *"Paracetamol is dished out like lollies."* Custodial staff are required to complete a record of the amount of paracetamol issued to prisoners, so over-issuing should be readily identified.

The issuing of medication is primarily a function of Health Services staff. However, in a prison setting where nurses are not usually unit-based, the issuing of mild pain relief by staff is appropriate. Nonetheless, staff must be particularly vigilant in recording the names of prisoners receiving paracetamol and the dose they receive.

(ii) The high cost of prescriptions

The type, dose and duration of medicine prescribed to prisoners is the prerogative of prison Medical Officers. Prescriptions are filled by local pharmacies and few, if any, problems were raised regarding arrangements between prisons and local pharmacies. Prescriptions are usually faxed to the pharmacy, and prisoners receive their medication promptly.

Health Services complained about the high cost of prescriptions and the wastage of medication when prescriptions are changed, or when prisoners refuse to take their medication. At some prisons, our Investigator observed large plastic bags containing unwanted medication. The medication was not required either because the prisoner had been prescribed something else (blister pack medication cannot be given to another prisoner), or the prisoner had refused to take the medication prescribed.

Blister pack medication for a prisoner is sent to prison usually in a one month bulk lot. A week's supply of medication is given to prisoners who self-administer. If a prisoner refuses to take the medication after, say, the first one or two days, the remainder of the medication cannot be used.

The Department's Health Service is funded via Vote Corrections, not Vote Health, and thus the Department's Health Services is not registered as a Primary Health Organisation. Primary Health Organisations are funded by District Health Boards to provide essential primary healthcare services to those people who are enrolled with Public Health Organisations.

New Zealand citizens and certain other categories of New Zealand residents are eligible for publicly-funded health and disability services.

Publicly-funded healthcare means that patients receive reduced General Practitioner fees, and since 1 September 2008 pay only \$3.00 for prescription fees, provided that the medication is fully subsidised and from the patient's usual Primary Health Organisation General Practitioner.

Prisoners do receive publicly-funded healthcare, but the cost of prescriptions to the Department is considerably higher than the subsidised funding available via Primary Health Organisations.

We do not consider that the current funding arrangement is desirable. The fact that the Department's Health Service is not a Public Health Organisation places a burden on otherwise scarce financial resources, and the cost nationally to the public is worrying. Our views are discussed further in Chapter 20 "Future Options for the Funding of Health Services".

Our understanding is that the Department does not keep a record of the amount of medication that is unused. A Health Centre Manager suggested a wastage rate of 20% would not be unrealistic.

We recommend that the Department assess the cost of medication wastage and consider ways to reduce the cost of unused medication.

In its response to the Draft Report, the Department said:

"The Health Service uses 'blister packs' to contain individual prisoners medication as this meets regulatory requirements for medication packaging and is the most common form for packaging medications. Combined with the high health needs of prisoners (often requiring frequent medication changes) and high turnover for prisoners, there will always be some wastage of medications. In accordance with the Medicines Act, medication which is provided by the pharmacy for an individual cannot be given to another person if they are no longer required by the original person. Pharmac regulations are not flexible on the prescription and dispensing of medications. Since mid-2010, Health Services has worked with Pharmac in an attempt to review their approach to prisoner medication. We will continue to monitor pharmacy expenditure and to work with Pharmac to progress improvements."

(iii) Prisoners who self-administer medication

Giving a prisoner responsibility for his/her own medication is consistent with the goal of a gradual reintegration into the community.

As already indicated, the Department allows prisoners to receive unit-dose or blister pack prescription medication for self-administration. Usually a week's supply of medication is issued. Health Services issue prisoners blister pack medication, although in the event that Health Services staff are unavailable to do so, custodial staff can undertake this duty. Prescription medication administered by custodial staff is done in accordance with written instructions provided by Health Services staff. A Unit-Dose Packaged Prescription Medication Log is maintained in units to help ensure that medication is issued to the correct prisoner.

The Department's Health Service Manual clearly sets out the guidelines for managing prisoners on unit-dose medication. There have been instances, however, where the management of prisoners who self-administer has been found wanting.

For example, on 19 November 2009, during a routine cell search, 188 tablets were discovered concealed in a shampoo bottle. The medication included 52 Voltaren and 136 Dothiepin tablets. Dothiepin is used as a sedative for depression and anxiety. Health Services staff confirmed that the tablets belonged to the occupier of the cell being searched.

Health Services staff told us that the assessment for prisoners considered for self-administration takes into account such aspects as the comments of custodial staff, insofar as the prisoner's general compliance is concerned, and the type of medication to be self-administered. That said, even the most robust assessment methods used may not always identify prisoners' propensity to hoard or misuse medication.

In our opinion, prisoners who have approval to self-administer should be frequently monitored by nursing staff. Spot-checks by custodial staff and routine cell searches that pay particular attention to prisoners' compliance with medication may help alleviate misuse.

At one prison our Investigator visited, prisoners are not permitted to self-administer. The Prison Manager's view is that medication in prisoners' cells is a custodial matter, not a health matter. While such decisions are within Prison Managers' discretion, we see no justification for differences in approach. There should be a national policy. There is no logic in removing a prisoner's opportunity to self-administer simply because that prisoner has been transferred to another prison.

We recommend that the Department:

- 1. monitor prisoners who self-administer medication on a frequent and regular basis; and**
- 2. review the self-administration policy to ensure that there is consistency of approach across all prisons.**

In its response to the Draft Report, the Department said:

"The Self Administration of Medication by Prisoners policy (last updated 14 May 2010) sets out the process to ensure that self-administration of medication by prisoners is managed in a manner that minimises the risk of harm to the prisoners and others. To ensure a consistency of approach across prisons, an audit on compliance with policy will be conducted. The next audit is scheduled for medication will be May/June 2011 as part of the Getting the Basics Right Audit."

(iv) The issuing of medication

The issuing of medication to prisoners is achieved in different ways. The Department requires that some prisoners are escorted to a Health Centre to receive medication. Other prisoners are given a single "supervised" dose once or twice a day from a nurse in prison wings, or if self-administering, a supply of medication is kept in a prisoner's cell.

Prisoners claim that medication is inadvertently issued by Health Services staff to the wrong prisoner. If this has occurred, it is human error, rather than any systemic failure on the part of Health Services. Nonetheless, it was worthy of our attention. It is perhaps an indicator, especially at larger sites, of the number of prisoners requiring medication and the pressures placed on nursing staff to issue medication at specified times.

Medication, other than that issued at Health Centres, is usually issued in the morning and again at about 4.30pm. At some prisons, medication is issued at a later time in the evening. Most prisons in the country operate on an 8-5 regime, which means that prisoners are unlocked at about 8.00am and locked-down again before 5.00pm.

The problem of medication being issued early in the evening is an issue on which prisoners have commented. If the medication is for sleeping and is taken too early, the prisoner may fall asleep too early and may wake up well before dawn. Other than prisoners who self-administer, the Department's policy is that prisoners must take their medication at the time it is issued. In an effort to reduce diversion of medicine, it is consumed with water or milk in the presence of a nurse.

Even the procedure of ensuring medication is taken with milk or water does not always ensure that it has been ingested. In a departmental incident report recently sent to this Office, we were advised that three purple pills had been found in a prisoner's cell. Custodial staff contacted Health Services and they were advised that the medication had been prescribed to the prisoner, and that it had been issued during the evening medication round to be taken then and there. We say so to make the point.

An interview with a woman prisoner recounted her frustration with the timing of prison medication rounds. She said on her prison medication chart, medication should be issued by nursing staff at 8.00am, 12 noon, 4.00pm and 7.00pm. This, she said, is rarely adhered to.

Our view is that prison routines should not override the medical necessity of providing medication at an appropriate time of day for therapeutic purposes. Medication required to be taken at, say 7.00pm, should occur, and the timing should not be subservient to custodial requirements.

The Department advised: *"Medication rounds are managed according to the daily cycle of the prison activity."* To ensure that the issuing of medication within the daily cycle of prison activity provides the optimum clinical benefits for prisoners, we suggest that Health Services actively consider the times that medication is issued. Ultimately, of course, it is for the Department to ensure due liaison and accord between Health Services and custodial needs. Despite the statement of the Department quoted in this paragraph, it seems that due management is not occurring.

Ideally, all medication should be issued at a Health Centre, rather than in prison wings. Health Centres afford more privacy and ensure that the health needs of prisoners are met in a health-centred environment. However, we accept that the large number of prisoners receiving medication and the custodial resources required for escorts to a Health Centre facility would make this difficult.

The prescribing and issuing of medication is complicated when prisoners transfer to another District Health Board (DHB) and come under the care of another Regional Forensic Psychiatry Service. For example, prisoners at Whanganui Prison under the care of Capital and Coast DHB Forensic Services may have their medication changed should they be transferred to New Plymouth Prison (Waikato DHB).

Up until about four years ago, New Plymouth, Manawatu and Hawkes Bay Regional Prisons sent their At Risk prisoners to the Whanganui Prison At Risk Unit. Hawkes Bay Regional Prison was removed from the catchment area when an At Risk Unit was built at that prison and opened early last year.

At Risk prisoners from New Plymouth Prison and Manawatu Prison were still transferred to Whanganui Prison.

In the course of managing the At Risk Unit, the unit manager noticed a familiar pattern emerging from prisoners being transferred from New Plymouth Prison. Many prisoners complained that the forensic oversight they were receiving in New Plymouth Prison was not consistent with what they were receiving in Whanganui Prison.

One prisoner who was frequently transferred from New Plymouth Prison would be seen by the Medical Officer at Whanganui Prison and in time would be cleared from At Risk status. He would be transferred back to New Plymouth Prison. On the prisoner's return to New Plymouth Prison his forensic care would be overturned or changed. He would often revert to At Risk status and be transferred back to Whanganui Prison.

It seemed nonsensical to the unit manager to have prisoners who, on their return to their home region, came under another Forensic team. He suggested to have New Plymouth Prison transfer their At Risk prisoners to the Waikeria Prison At Risk Unit. Both prisons come under the Waikato DHB's Forensic oversight.

The matter was resolved, but it did highlight some of the difficulties of providing healthcare in a prison environment.

(v) Prescribing rights

Until 2005, only Medical Practitioners registered under the Health Practitioners Competency Assurance Act 2003 had the legal authority to prescribe medication. Nurse practitioners in aged-care and child family health had limited prescribing rights. That is, they could prescribe prescription medicines to consumer groups who have conditions that fall within particular prescribing parameters that take into account the scope of practice, client/age group, disease condition and setting.

Legislation establishing Nurse Practitioner prescribing was enacted in September 2005. Nurse practitioners are now able to prescribe a broader range of prescription medicines and controlled substances.

In June 2010, 80 Nurse Practitioners were working in New Zealand. They work in a variety of specialty areas.

Departmental nurses said that study towards higher qualifications is available but is not something that is proactively encouraged by the Department.

As the Nurse Practitioner role develops, we assume that many more nurse practitioners will be working in increasingly diverse settings; with many different communities and teams and in many different roles.

Nurse prescribing is adopted as a means of improving service efficiency, particularly where demand outstretches resources. With this in mind, we invite the Department to consider whether it would be advantageous to assist and actively encourage its nurses to study towards higher nursing qualifications.

There is a question whether prison nursing could be promoted as a specialist field of expertise which is accredited and taught as a specific module in the tertiary nursing qualification. That is beyond the scope of this investigation, however we drew this matter to the attention of the Nursing Council.

Subsequently, the Chief Executive/Registrar of the Nursing Council advised us on 19 August 2011 that the Council is currently undertaking a review of its post-graduate education standards. She said the Chief Ombudsman's comments regarding prison nursing as a specialist field of expertise would be included as part of that review.

(vi) Restricted medication

Although prisoners should take responsibility for their own health needs in the interests of promoting the same responsibility after release, imprisonment creates circumstances which may prevent this. Drugs of almost any kind will be sought by certain sections of the prison population. This gives rise to bullying of prisoner-patients in lawful possession of them. Sometimes prescribed medications will be hoarded – with the potential for an overdose leading to death.

There appears to be a lack of consistency regarding the prescribing of some medication. Medication which has particular potential to be misused or used as “currency” is prescribed in some prisons and not in others. This leads to frustration when prisoners have existing medication withdrawn when they are transferred to another prison and substituted by other medication. The result of this is often stand-over tactics and abuse directed towards Medical Officers and nurses.

A prisoner was prescribed an antihistamine spray by a Medical Officer. When he was transferred to another prison, the Medical Officer said the spray would not be prescribed. The prisoner protested and said that without the spray he would get migraines. He was advised to take paracetamol. We cannot comment on the quality of medical judgment, but we accept that the prisoner believed proper healthcare was being denied at that prison.

Prisoners complained that that they had been prescribed a dietary supplement by a Medical Officer, only to be advised one or two days later by a nurse that the prisoners would no longer receive it. The particular dietary supplement concerned is not usually prescribed to prisoners because it is a very tradable item. The Medical Officer agreed with nursing staff advice that the supplement should not have been prescribed.

Different approaches to the prescribing of medication are apparent at different prisons. There are even seemingly different views between Medical Officers at the same prison. A prisoner complained that he had been prescribed a particular drug for neck pain by a specialist in the community. When he was received at prison, the Medical Officer who assessed his health needs continued to prescribe this medication. After taking the medication for 17 months, another Medical Officer at the same prison denied further prescription and insisted on substituting a different drug.

It seems unreasonable to us if prisoners have their medication changed arbitrarily in this way without therapeutic reason, and simply because of a different practice towards that drug at another prison.

We see no reason why usual patient choice should not apply in such circumstances. If security concerns mitigate against the prescription of certain drugs, so be it – but the practice should operate on a consistent national basis.

It seems to us that it would not be difficult to compile a list of nationally-restricted drugs which should not be prescribed in the absence of special therapeutic reason always assuming that an alternative drug of similar therapeutic value is available. Such a list could easily be amended from time to time as medical experience in prisons might demand.

We recommend that the Department identify and circulate nationally a list of any restricted medications. The list should not, however, preclude a Medical Officer from prescribing a drug from that list for a sound clinical reason.

In its response to the Draft Report, the Department said:

“Medical Officers were consulted during the development of the Medicines Policy and Procedures Policy (last updated 14 May 2010). It was agreed that the best approach to prescribing medication with economic value in the prison environment was a preference for a clinically suitable alternative medication or treatment option. If there is no alternative, then a plan to safely manage the medication and/or prisoner’s treatment must be implemented (Section 6.1). The Department will consult with Medical Officers again to determine if a ‘restricted’ medication list would inhibit best clinical practice, however past consultation with the Ministry of Health (MoH) and District Health Boards (DHBs) on this issue has highlighted that significant resource would be required to maintain such a list.”

(vii) Refusal to take medication

Health Service staff told us that one of the most frustrating problems they encounter is prisoners who refuse to take medication.

The reasons for not taking medication may include unpleasant side-effects or a disbelief that he/she is ill, particularly mentally ill, and therefore there is no need to take medication. Staff also suggested that a reason why prisoners refuse to take medication is that it helps prisoners feel in control of their environment. In an institutionalised setting where prisoners are told when to wake, eat, attend programmes or work, the taking of medication is one thing they have a right to control. Prisoners, like members of the general public, are entitled to refuse medication or other medical treatment.

(viii) Adulteration of medication

The Department said there are times when prisoners receive a crushed form of medication which can be suspended in a liquid. This is done on the authorisation of the Medical Officer or specialist doctor, and it is used for prisoners who might contrive to save a solid pill by hiding it under their tongue by or other means.

It is important, in our view, that the effectiveness of the medication is not altered by crushing, etc. We make this point as we are aware of occasional past problems in this respect. However, no such problem was drawn to our attention in the course of our investigation.

(ix) Standing Orders

Because Medical Officers do not have a 24-hour presence on-site, nurses have the authority to issue medication as prescribed by the Medical Officer’s Standing Order. This is done in an emergency or when the Medical Officer is unavailable.

The Standing Order lists that were examined vary in the type of medication Health Services staff are permitted to issue.

The Department said: *“Lists are not standard across the country. They are issued by the Medical Officer or dentist who works at the prison and are developed in consultation with relevant Health Services staff”.*

A difference in the type of medication at various prisons is to be expected. There may, for example, be environmental considerations that may necessitate a preference for one type of medication over another. A prison close to a pine plantation may increase the prevalence of hay-fever and associated conditions. Also, Medical Officers may have a clinical preference for one type of medication over another.

(x) Methadone

We understand that Methadone Hydrochloride is a synthetic compound that has similar effects to natural opiates. It has similar pain relief properties to morphine. Methadone was first used to treat opioid addiction in the United States of America in the 1960s, and the first Methadone clinics opened in New Zealand in 1971. Early programmes were focused on abstinence as the goal (whether patients wanted abstinence or not), but the advent of HIV/AIDS saw a shift in philosophy and practice to the goal of reducing the harm caused by illicit opiate use.

According to the Department, as at 28 July 2011, 89 prisoners were receiving methadone in prison.

The Department placed strict controls around the issuing of methadone to prisoners after the drug overdose of a prisoner in 2000. The prisoner had over-represented her customary drug misuse, and consequently received too much Methadone while in prison.

Present controls include having no Methadone cut-off date for prisoners. Prisoners can therefore remain on the drug indefinitely. This is because of a concern that ex-prisoners who, having lost their tolerance to opiates if methadone is withdrawn, may die of heroin overdose shortly after their release from prison in the event that they relapse.

Prisoners receive methadone directly from nurses on a one-to-one basis, under the supervision of custodial staff. Methadone is taken in a liquid form and mixed with milk before ingestion. Prisoners are then separated from others for up to half an hour afterwards to limit their ability to vomit it and pass the substance to others by that means. Methadone is mixed with milk to make it unpleasant in the event that it is regurgitated.

Prisoners taking methadone may be held in an area that does not reflect their level of security or supervision. It is far easier for staff to manage the escorting of prisoners to and from the Health Centre if they are housed in one central location, rather than distant units.

The provision of methadone for prisoners appears to be routine and organised. However, at some prisons, the placement of methadone-dependent prisoners may not allow access to the programmes or work opportunities to which they would otherwise have access in less secure surroundings.

A Principal Corrections Officer said issuing Methadone to prisoners in her particular part of the prison is time consuming because prisoners have to be escorted to the Health Centre. She remarked that: "Prisoners who receive methadone 3 times a day could, because of their security classification, be held in a less secure area of the prison. But they have to be held here."

We have no concerns regarding the Department's administration of the Methadone programme itself. However, it is of concern to us that during our investigation, training courses for nurses regarding the methadone policy had been cancelled.

Our understanding is that the Department's health budget within Prison Services is not ring-fenced. Thus, if custody budgets are overspent, pre-agreed health budgets can be reduced. In this event, nurses are expected simply to read and absorb the methadone policy for themselves. In the past, nurses met as a group, usually on a regional basis, to discuss policy implementation and other matters affecting their regions. We feel it is unreasonable to expect nurses to be fully acquainted with health policy unless comprehensive training is provided. Comprehensive training in Health Services policy is important if the health needs of prisoners are to be adequately met. Proper methadone administration is a matter of direct relevance to life and death for heroin addicts.

We recommend the Department reinstate comprehensive training for nurses in relation to Health Services policy and ring-fence the health budget.

In its response to the Draft Report, the Department said:

"Nurses receive training in health services policy as part of their induction. When new policies are introduced, appropriate training is provided as required. The most appropriate method of delivering training is determined by the Health Management Team and is based on the complexity of the policy or activity to be introduced. The Nursing Council of New Zealand requires Registered Nurses to remain up to date with current clinical practice. The Department supports this providing learning opportunities and funding professional development."

With regard to the ring-fencing of the health budget, the Department said:

"As with the wider health and public sectors there is an expectation that we (the Department) operate in a manner which is both effective in terms of service delivery as well as efficient in terms of expenditure. Where government signals that savings should be made we have a responsibility to contribute to these. In your report, you note that if "custody budgets are over spent, pre-arranged health budgets can be reduced". On no occasion has Health Services been expected to reduce its expenditure in order that funding might be transferred to either custody or any other part of the Department. Having given consideration to your recommendation, our view is that it is not necessary to change the current approach to funding."

We do not suggest that Health Services funding has been transferred to custodial services. However, should the Department as a whole be forced to limit or reduce its overall spending due to unforeseen circumstances, this may impact on the ability of Health Services to provide a full range of services. Unless the Health Services budget is protected, the failure to adequately treat unwell prisoners while they are imprisoned will ultimately place greater demand on District Health Board Services when they are released back into their communities.

(xi) Lack of psychosocial intervention for prisoners taking methadone

Section 5.2 of the Practice Guidelines for Opioid Substitution Treatment in New Zealand, Ministry of Health, 2008 states:

"In respect to interventions provided, a wellness oriented system of care should incorporate a range of individual psychosocial interventions as well as family, cultural, gender-specific and peer-based interventions."

A National Methadone Treatment Programme is supported by DHBs and ideally the programme should include psychosocial counselling or intervention. Psychosocial interventions encompass a wide range of actions from “talking therapies” such as cognitive behavioural or family therapy, to supportive work on practical issues.

Ongoing support may include, but is not limited to, providing:

- information and education on health issues, especially on living with the treatments available for, and minimising the spread of, infectious diseases such as HIV/AIDS, hepatitis B and C, and sexually-transmitted diseases;
- information on general health and welfare issues, including social roles and social functioning (for example, employment, education/training, parenting, keeping children safe while the client/tangata whai ora is using drugs);
- information on and/or referral to other available community health and social services, such as family planning agencies, budget services and childcare facilities, and support in the areas of child development and parenting, accommodation and employment; and
- concurrent psychotherapeutic and social interventions (including ethno-cultural programmes and self-help groups) offered either by the specialist service or by other appropriate health or social service agencies.

Furthermore, with specific reference to prisoners, section 5.2 of the Practice Guidelines state:

“Specialist services are expected to provide psychosocial interventions to clients/tangata whai ora who are receiving OST (Opioid Substitution Treatment) while in prison. If the prisoner client/tangata whai ora comes from outside the prison’s region, the service of that client’s/tangata whai ora’s origin should provide ongoing liaison with the client/tangata whai ora and should negotiate with the local specialist OST service to provide the client/tangata whai ora with a psychosocial intervention as required.”

Our investigation would tend to suggest that prisoners receive little in the way of psychosocial intervention. The Canterbury District Health Board appears to be the only one that provides psychosocial intervention within prisons.

A prisoner told us that specialist services provided by the local District Health Board seldom visit him at prison.

In relation to follow-up visits by Alcohol and other Drug Services, a regional Health Manager told us that the service is supposed to provide 3-monthly minimum follow-ups for each prisoner on the methadone programme. This rarely happened.

The lack of psychosocial intervention for prisoners may be symptomatic of problems regarding the provision of psychosocial intervention in the community. Psychosocial intervention is not a function of the Department to fund or provide. However, it may want to identify any institutional barriers that preclude fuller involvement of specialist Alcohol and other Drug Services in prisons.

(xii) Medication prescribed at hospital prior to a prisoner's return to prison

Medication prescribed to serving prisoners by hospital staff (when prisoners have been temporarily removed to hospital) is often removed from prisoners when they return to prison.

In late 2008, before his discharge from hospital, a prisoner had been prescribed fast-acting Morphine. The medication was taken from the prisoner upon his return to prison. Health records state that he was discharged from hospital with a controlled drug prescription for the drug as well as a codeine-based medicine. The Medical Officer said Morphine analogs¹ are not used in the prison unless there are very compelling clinical indications. In this instance, the Medical Officer did not believe there was a case for those medications.

An older prisoner at Whanganui Prison said he had recently undergone a hernia operation and the medication prescribed at hospital for pain relief was withdrawn upon his return to prison. The Medical Officer advised him that he could not have the medication previously prescribed, but liquid paracetamol would be provided. The prisoner claimed it provided little in the way of pain relief.

When received back at prison from dental surgery at hospital, a prisoner told us that he was prescribed three types of analgesia. Prison nurses are not permitted to issue medication that is not blister packed from a local pharmacy. Only one type of pain relief was provided at prison until blister-packed medication could be prescribed.

If a prisoner considers he/she is not receiving due medical attention at prison, he/she may complain to the Health and Disability Commissioner. However, this process takes time and, in our view, should never be necessary when the issue is simply prison policy towards a particular drug.

It is important, we believe, that there is a formal hand-over of prisoners at hospital to Health Services staff to ensure any issues regarding hospital-prescribed medication in relation to prison policy are discussed. Unwell prisoners should not be caught in the middle of any dispute and be expected to sort it out themselves by recourse to the Health and Disability Commissioner.

We recommend that the Department develop and implement a formal hand-over policy with hospital authorities.

In its response to the Draft Report, the Department said:

"The Healthcare Pathway Policy and Procedures (Sections 11 and 12) set out expectations about the engagement between Health Services and external health providers (such as DHBs). The Department has also developed a secure bag process to transfer paper-based records between service providers to ensure privacy of health information. Each regional Health Service will have a Memorandum of Understanding/Service Level Agreement with its DHB which describes the interface between the services, including the sharing of information. The Department intends to audit the Memorandums of Understanding / Service Level Agreements to ensure these are in place and current for all sites."

(xiii) Medication removed at the time of a prisoner's reception at prison

An ongoing risk that requires managing in prison settings is the obtaining and use of prescription drugs for illicit use.

¹ A structural derivative of a parent chemical compound that often differs from it by a single element.

In general, newly-received prisoners have prescribed medications removed from them unless the following criteria are met:

- the pharmacy label must be intact and information regarding the drug name, dose, prisoner name, prescribing authority, dispensing pharmacy and administration instructions must be clear; and the medication must have been dispensed within the last three months;
- the medication has not passed its expiry date; and
- the medication is in its original packaging.

Clearly, departmental staff must remove any medication from prisoners until such time as medical staff can identify the medication and confirm that it was lawfully prescribed. However, if the criteria above have not been met, yet the medication is for legitimate use, the removal of the medication may cause significant apprehension at a time when prisoners are most anxious.

The removal of medication is, of course, distressing when a prisoner is, for example, on chronic pain medication for an historic back injury, antidepressants, or other mental health medication. Prisoners accustomed to codeine-based medication for pain relief before prison will often have this medication substituted by paracetamol.

The withdrawal of medication may mean that the prisoner, during the period of withdrawal, is not receiving medical treatment that is “reasonably necessary” within the meaning of section 75(1) of the Corrections Act. If this were the case, we would have no hesitation in saying that this would be wrong, and any administrative problems should be overcome.

A prisoner said that he did not receive previously prescribed heart medication for five days after his arrival at prison. This was later verified as correct.

The period of time taken to confirm the type of medication previously prescribed by a General Practitioner or specialist is hindered by the fact that Health Services do not have immediate access to prisoners’ previous health records. At the time of a prisoner’s reception, Health Services staff initiate an electronic medical record called MedTech. It is a departmental system and it does not include previous health information held by General Practitioners.

The Department said: *“It does not provide a direct link to GP clinical databases and we will continue to rely on them (General Practitioners) to action any requests for information”.*

In our opinion, any delay in obtaining prisoners’ health information is undesirable, and may be unreasonable or wrong in terms of section 22(2) of the Ombudsmen Act. Sharing the same database as other health professionals would greatly assist the Department to attend to the health needs of prisoners on reception.

We recommend that the Department consider the feasibility of linking the MedTech system with community providers’ electronic health records.

In its response to the Draft Report, the Department said:

“MedTech is the most widely used electronic clinical record system amongst primary health providers in NZ. Linked services are able to share information (for example, all prison Health Centres are able to access information on any prisoner in New Zealand, and all GPs belonging to a particular practice are able to share information). However, the technology currently available in New Zealand does not enable the sharing of information between services that are not linked. The exception is via the Healthlink service which enables laboratory test results and the NHI numbers to be obtained throughout the country by all healthcare providers. The Department monitors new initiatives to ensure we have up to date information on potential developments for linking health services electronically in the future. We have also asked to be involved in the MoH project considering how the health sector can better share electronic records.”

(xiv) Non-clinical time

Prisoners are dependent on Health Services staff to issue medication, whether this is at a Health Centre, prison wing or unit clinic.

A significant amount of a nurse's time is taken up with the physical issuing of medication to prisoners. The issuing of medication is not usually viewed as a Primary Healthcare function. In the community, persons will obtain their medication from a pharmacy and simply follow the written instructions on the container.

It was suggested by a Health Centre Manager that 50% of a nurse's time is not clinical - it is taken up with walking to or being transported to units, waiting at units, preparing hospital lists and preparing information regarding prisoner transfers. Another Health Centre Manager said that of the 278 prisoners at the prison, 39% are receiving daily medication.

Clearly, the amount of time taken to issue medication will vary depending on the size of the prison. Some prisons are relatively compact in size and issuing medication is not overly time-consuming. At larger sites, such as Tongariro/Rangipo Prison, the distance between the Maori Focus Unit (Te Hikoinga) and the outermost unit, West Camp, is approximately 17 kilometres. The size of this prison presents a challenge for Health Services staff and how they manage the issuing of medication. The prison, because of its relative isolation, has had difficulties in the past attracting nurses and this has impacted on the ability of Health Services to fulfill routine medication duties.

At most prisons, daily medication rounds are frequent, and while we heard about delays and other problems associated with issuing medication in a prison setting, prisoners' access to their medication is generally well-organised and routine. We feel it is a poor use of resources to take qualified nurses away from true clinical duties, only to assign them to what is often no more than supervising the swallowing of medication. The Department may want to consider an alternative to registered nurses issuing medication, and whether lesser qualified staff could be employed for this purpose.

(c) Treatment

(i) The treatment of non-serious injuries

Treatment of non-serious injuries such as sprains, cuts and grazes appears to be well managed by Health Services staff. If assistance is required outside the Health Centre, staff are prompt to respond and provide appropriate treatment(s) if required. Injuries such as those caused by sporting activities can be dealt with at Health Centres or unit clinics, but, for more serious injuries, outside medical attention is often required.

During our investigation few nurses said they had been trained to suture. A nurse with 11 years' experience told us that prison nurses used to be able to suture using "suture glue". Another nurse said it is unfortunate that butterfly-stitches used by nurses in the United Kingdom are not used in New Zealand prisons.

The training of nurses to suture is an important part of the wider scope of practice for Health Services staff. It is no more than common sense to observe that prison suturing may avoid an escort to hospital with the consequent burden on both custodial and hospital staff.

We were minded to recommend that the Department view the training of nurses to be able to suture as a core competency.

In its responses to the Draft Report, the Department said:

"The demand is not sufficient for this level of coverage and if a skill is not being used regularly then it is difficult to maintain competency. For this reason, it is not considered necessary to make suturing a core competency. If individual sites believe that there is a need to have nurses trained in suturing based on the number of prisoners presenting with injuries requiring this intervention then they are able to facilitate this."

We made further inquiries. The Department said:

"In order for Health Services staff to suture, they would be required to undergo a competency assessment. This would require demonstration of an appropriate level of skill under the supervision of an experienced clinician and education around assessment and management of wounds. There would be an expectation that Health Services did not suture hands or faces, as these areas require a higher level of competence."

We are advised by the Department that it is not common practice for nurses at General Practitioners' practices in the community to suture.

We note, in particular, the comment that if individual sites believe there is a need to have nurses trained in suturing techniques, then this will be facilitated. If individual sites with particular needs are able to ensure that its nurses are suitably trained, we would regard the situation as satisfactory.

(ii) The provision of electrocardiograph machines

An electrocardiogram (ECG) is a diagnostic tool that measures and records the electrical activity of the heart. Interpretation of these results allows diagnosis of a wide range of heart conditions. An electrocardiograph is the apparatus used to generate electrocardiograms.

The Department provides the number of electrocardiographs in prisons on the basis that a prison is more than one hour away from a secondary service machine, or the prison undertakes more than ten electrocardiograms per month at a secondary service. A secondary service is a hospital or community medical centre that is open 24 hours a day.

Currently, the prisons that have electrocardiographs are Northern Region Corrections Facility, Auckland Prison, Mt Eden/Auckland Central Remand Prison (now Mt Eden Corrections Facility), Auckland Region Women's Corrections Facility, Spring Hill Corrections Facility, Waikeria Prison, Tongariro/Rangipo Prison, Rimutaka Prison, Christchurch Men's Prison and the Otago Corrections Facility.

The Department considers the use of electrocardiographs in prison Health Services will ensure that prisoners have the same access to health services as the wider community. This particularly applies to rural areas where prisoners may be some distance from secondary health services. We agree with this.

It became apparent as our Investigator visited each prison, that some Health Services staff had concerns regarding the use of electrocardiographs, and the training of staff to use them. We suggest that the Department canvass its medical professionals and, if need be, amend its policy regarding the use of electrocardiographs in prisons to facilitate correct usage.

(iii) Treatment plans

The Department requires a treatment plan be devised for prisoners who have significant and/or complex health needs. The Department describes a significant and/or complex need as:

- any chronic disease (including mental illness);
- acute diseases, conditions or injuries that place the prisoner at significant risk (including mental illness); and
- any disability, condition, disease or illness that requires complex nursing or medical intervention (including mental illness).

A Health Centre Manager told us that a treatment plan is usually devised according to the current management of a prisoner's condition. For example, a prisoner with asthma who is stable would not usually require a plan. Conversely, a prisoner having frequent attacks that resulted in hospital admission would require the development of a treatment plan. A prisoner with a serious illness would have a treatment plan developed.

In developing a plan, Health Services staff are required to review relevant clinical documentation, consult appropriate internal and external services and involve the prisoner in the development of the plan of care, and to document the plan of care. The treatment plan should document aspects such as:

- the identified clinical problems;
- the proposed interventions or outcomes;
- the clinical management; and
- the timeframes for reviewing any interventions.

Health Services have some input into a prisoner's sentence plan, for example, whether or not a prisoner is fit for heavy work. Health needs and their treatments have a significant bearing on how a prisoner's sentence is managed, particularly in respect of location and the type of external health services readily available at particular prisons.

Some prisoners entering prison have more than one diagnosable illness or health issue. For example, a prisoner may have substance abuse problems in addition to one or more mental health disorders. Each disorder affects the course of the other and the outcome of treatment, and therefore the need for integrated services should be adequately reflected in both treatment and Sentence Plans.

We conclude that development of individual treatment plans for prisoners support both Health Services and custodial staff in the overall management of prisoners.

(iv) Alcohol and Drug treatment programmes

The Department funds and provides Alcohol and Other Drug (AOD) Programmes in prison. The focus of these services is on the rehabilitation of prisoners. It is therefore a departmental function and not a Ministry of Health function.

The importance of appropriate substance abuse programmes is highlighted in the Department's Drug and Alcohol Strategy 2009-2014. It states:

"Drug and alcohol misuse also creates relationship difficulties and financial hardship and causes health risks, including drug dependency, heart and liver disease and the risk of mental illnesses such as depression. Drugs and/or alcohol were factors in 30 per cent of all fatal road accidents during 2005-20073, and 70 per cent of all weekend Accident and Emergency admissions are related to alcohol use. The cost to society of harmful drug and alcohol use is estimated at \$1.5 billion per year."

The Department provides group-based programmes, set within a therapeutic environment, for prisoners with alcohol and drug related issues, or for whom alcohol and drugs is a criminogenic need. Criminogenic needs programmes address dynamic risk factors that, when changed, are associated with the probability of recidivism.

Six-month programmes are delivered by Care NZ in six drug treatment units based at Arohata Prison, Rimutaka Prison, Spring Hill Corrections Facility, Christchurch Men's Prison, Waikeria Prison and Hawkes Bay Regional Prison.

Care NZ provides services for people (not just prisoners) affected by drug abuse, dependence and alcoholism throughout New Zealand - including residential care, school and education programmes, general counselling services and workplace support, both within and outside the workplace. Care NZ is the delivery arm of the New Zealand Society on Alcohol and Drug Dependence (NSAD).

Three-month "intensive" programmes are delivered by Care NZ in two drug treatment units at the Otago Corrections Facility and Whanganui Prison, and by Odyssey House in a drug treatment unit based in Auckland Prison's West Division. In 2010, the Department of Corrections announced that Odyssey House had been selected to deliver an intensive drug treatment programme at a specialist unit at the prison. The unit will house 48 prisoners, and run three courses a year – providing treatment for an additional 144 prisoners in the Auckland area.

Three-month "intensive" programmes deliver the same treatment hours as the six-month programmes, but over a shorter timeframe, hence the term "intensive". The aim of the programmes is to reduce re-offending by assisting programme participants to address their dependence on alcohol and other drugs.

Prisoners wishing to attend an AOD programme must be identified as alcohol or drug-free, provide two negative drug tests in the two months prior to commencing the programme, or one negative test and have a second test pending.

Section 123 of the Corrections Act 2004 requires the Chief Executive of the Department to issue a drug and alcohol strategy relating to drug and alcohol use by prisoners. Furthermore, regulation 145 of the Corrections Regulations 2005 establishes a random testing programme known as the identified drug user (IDU) programme. It provides that prisoners may be tested for drugs and alcohol on reasonable grounds, or as part of a random selection process. If convicted of a disciplinary offence involving alcohol or drugs, a prisoner is placed on IDU Status.

IDU Status is applied by the Department to prisoners for the purpose of providing special management for all prisoners identified as drug users. The sanctions that may flow from a proven disciplinary charge relate to loss or postponement of privileges, forfeiture of earnings and/or cell confinement.

Prisoners remain on IDU Status for 12 months once convicted of a drug-related disciplinary charge, unless they apply under the Identified Drug User Voluntary Check (IDU-VC) for removal of IDU Status. This requires that prisoners provide two urine samples over a period of eight weeks. If both tests return a negative result, IDU Status can be removed. Should prisoners return a positive test result while on the IDU-VC programme, they are not charged with a disciplinary offence. They do, however, have the level of IDU increased.

In our view, alcohol and drug abuse raises both health and social issues. The widened eligibility for treatment to prisoners is more in keeping with a health and social-based approach to treatment, rather than what appeared to be a punitive restriction.

In 2009 the Government announced its commitment to double the number of places in prison providing drug and alcohol treatment from 500 to 1000 prisoners per year by 2011. Significant progress has been made in this area with the opening of new Drug Treatment Units at the Otago Corrections Facility (2010), Auckland Prison (2010) and Whanganui Prison in 2011. The new units provide an intensive, short-term programme for shorter serving prisoners and brings the total number of Drug Treatment Units in the country to nine.

Chapter 8 - EMERGENCY SERVICES

(a) Emergency Equipment

The Department's policy is that every Health Centre has available emergency equipment that is able to be transported in an easily movable storage device. The Health Centre Manager is responsible for ensuring that the equipment is checked and that this is documented.

Emergency equipment includes a high concentration oxygen mask and tubing, oxygen cylinder, Automatic External Defibrillator (AED) and pocket masks for mouth to mouth resuscitation.

Some prisons place the emergency equipment on a trolley while others use a backpack.

(b) Checking of Equipment

The Department's policy is that for a prison with fewer than 150 prisoners, emergency equipment should be checked weekly. At larger prisons, emergency equipment is checked daily.

The small size of a prison should not, in our view, be a determinant regarding the regularity of emergency equipment checks. We see no rationale for this distinction. An emergency situation can arise at any time and emergency equipment must function properly at all times.

During a death in custody investigation it was found that one of the oxygen bottles contained in the emergency pack was missing. It was later discovered that the oxygen bottle was not in the medical area, but in an equipment room in a custodial area. This area was not able to be accessed by Health Services staff.

At a prison we visited, the AED usually placed in the emergency pack in the Health Centre is moved to the At Risk Unit overnight to cover any emergency. We enquired as to why the At Risk Unit could not have its own AED, if the risks were that great. We were told that cost was a prohibitive factor.

We can appreciate the concern of At Risk Unit staff should an emergency occur in the At Risk Unit at night. However, in the event of an emergency elsewhere in the prison, the time taken to acquire the AED from the At Risk Unit or the possibility that other staff do not know of the whereabouts of the AED, could have dire consequences.

In the Draft Report, we were minded to recommend that the Department review its policy regarding the weekly checking requirement at prisons with less than 150 prisoners.

In its response to the Draft Report, the Department said:

"The Emergency Equipment Policy was reviewed in 2010 and now all sites are required to check emergency equipment daily unless specific requirements are met."

(c) Automated External Defibrillators

Heart attack is the main cause of premature death in New Zealand. The New Zealand death rate from heart disease remains among the highest in the world, although there has been improvement in recent years. The current rates are lower than the United Kingdom but higher than Australia, Canada and the USA.

Defibrillation with an AED provides an electrical shock needed to restore a heart to its normal heart rhythm. According to the Order of St John, automated external defibrillators can increase the chance of survival by up to 40% when dealing with a sudden cardiac arrest.

AEDs are now found in such places as fitness clubs, schools and restaurants. There is a AED in the main reception area at the Department's National Office in Wellington.

Sudden cardiac arrest will sometimes occur. Having AEDs at prisons in the event of an emergency can greatly increase a prisoner's chance of survival. We have commented previously to the Department about the availability of AEDs.

Information from the Department showed that prisons in the Northern Prison Region (Northern Region Corrections Facility, Mt Eden Corrections Facility, Auckland Prison, Spring Hill Corrections Facility, Auckland Region Women's Corrections Facility) have one AED at each site.

Prisons in the Central Prison Region (Waikeria Prison, Tongariro/ Rangipo Prison, Whanganui Prison, Manawatu Prison, Hawkes Bay Regional Prison, Manawatu Prison) have one AED each.

In the Southern Prison region (Rimutaka Prison, Wellington Prison, Arohata Prison, Canterbury Prison, Otago Corrections Facility, Invercargill Prison) prisons have one or two AEDs.

Prisons such as Mt Eden Corrections Facility and Auckland Prison, with musters of 432 and 681 prisoners respectively (as at Jan 2010), have only one AED each.

Invercargill Prison, on the other hand, which is a small and compact prison with a maximum muster of 180 prisoners, has two AEDs. Rimutaka Prison with a maximum muster of 1038 prisoners and on a much more extensive site also has two AEDs.

Custodial staff are not trained in the use of AEDs. We are surprised by this, because defibrillators can be used by lay personnel. The AEDs we saw during our investigation use simple audio prompts and pictures to reinforce every step in the resuscitation process.

We recommend that the Department:

- 1. Review the number of defibrillators at each prison. Consideration should be given to the number of prisoners and size of the prison site; and**
- 2. Train and permit custodial use of defibrillators.**

In its response to the Draft Report, the Department said:

"Purchase of additional Automated External Defibrillators (AEDs) has been approved. Each site will receive an additional 1, 2, or 3 machines (depending on the size of the site).

Prison Services has begun the process to purchase additional AEDs for use by custodial staff, and will provide appropriate training in their use."

(d) The Storage of Emergency Equipment

Some prisons store their emergency equipment in a locked room in the Health Centre, while others have the equipment available in an open or unlocked area.

Subject to any security or safety reasons, we do not consider that emergency equipment should be placed in a locked area. Equipment should be easily obtainable by all staff.

We are of the view that emergency equipment should be able to be readily uplifted by Health Services staff or custody staff.

(e) Emergency Drills

The Department requires each prison to conduct an annual health emergency exercise. The mock exercise can be part of the wider Prison Services emergency mock exercises conducted yearly. Whole prison drills undoubtedly have their value. Equally, the value of drills primarily involving Health Services staff should not be underestimated.

Few Health Services staff could recall the last time when a specific health emergency drill had taken place.

One officer remarked that she had been at one prison for three years and during that time no specific health emergency drills had been held.

We suggest that the Department should review the dates that health emergency drills have taken place to assess whether or not Health Services staff are adequately prepared in the event of a medical emergency, and schedule new drills as appropriate.

(f) On-call Services

In 2005, the then Chief Ombudsman John Belgrave and Ombudsman Mel Smith in their own motion investigation in relation to the Detention and Treatment of Prisoners recommended that 24-hour nursing be provided at prisons, subject to exceptional circumstances.

The Department responded by stating that it provides *“Medical coverage at an equivalent level to that present in the community - 24 hour nursing is not available to the general public”*.

We note the Department's view.

We agree that the provision of 24-hour nursing is generally not available to the general public. However, visiting an after-hours doctor's surgery or hospital is certainly easier for members of the general public than for prisoners.

On-call nurses sometimes live a considerable distance from prison. For example, at Hawkes Bay Regional Prison, the nurses employed at the time of our inquiries lived 30 minutes from the prison. In the event that an on-call nurse does not attend to a prisoner by travelling to the prison, he/she will provide telephone advice and guidance for custodial staff regarding how to care for the prisoner. However, this will necessarily be done without access to prisoners' health records.

It is, in our view, unreasonable that nursing staff should be expected to advise regarding the health needs of a prisoner without access to that prisoner's health records. To enable nurses to be able to respond promptly and exactly to custodial requests regarding prisoners' health needs after hours, it is our opinion that they should have computerised access to prisoners' health records.

(g) Advanced Emergency Training for Custodial Staff

During an incident at the now closed Ohura Prison in 2002, a prisoner collapsed after playing volleyball. Staff members immediately commenced Cardiopulmonary Resuscitation (CPR) when it was discovered that the prisoner had stopped breathing and no pulse could be detected.

An ambulance was called for immediately and CPR was continued by staff for approximately 50 minutes prior to the arrival of the ambulance. Ambulance staff took over monitoring the prisoner's condition, but within a few minutes deemed that resuscitation attempts were unsuccessful. decision to cease CPR was made by attending ambulance staff. In this particular case, additional resuscitation equipment was available but departmental staff had not been trained in its use.

Following investigation of the incident, an Inspector of Corrections recommended that, due to the isolated location of Ohura Prison, and the time it would take for emergency services to respond to any serious medical issues, staff be provided with a higher level of training in first aid. Before the prison's closure in 2005, some staff were trained to a higher level of training in first aid.

In our view, it is not necessarily a prison's remoteness that warrants a higher level of emergency training for custodial staff. Even where prisons are in relatively close proximity to external emergency services, access to an emergency scene can be unavoidably delayed. Gates and prison grilles have to be unlocked, and the distance to some units within the prison site can be significant in terms of travel time.

If a higher level of emergency first-aid training for custodial staff is available, then in our view, it is warranted.

We recommend that the Department review the level of first-aid training for custodial staff.

In its response to the Draft Report, the Department said:

"The Department will further consider this recommendation, and identify what level of training is appropriate and sustainable."

(h) Emergency Distress Calls

During an investigation into a serious prison incident in 2009 we were informed by the prison manager that the prison did not have a specific emergency radio distress call. In this case, the fact that an emergency distress call was not used did not have a significant bearing on the outcome for the prisoner. Nevertheless, we were concerned that there was no nationally consistent medical emergency call in place.

Some prisons have adopted a code yellow radio call. Code yellow indicates that a "medical emergency" is in progress and Health Services should have unfettered access to the emergency scene.

We approached the Department with our concerns in October 2009 and were subsequently advised that the implementation of a standard radio distress call had been put on hold, pending the release of a standard set of call codes at the conclusion of a review of the National Incident Response Framework.

Although this is not a direct health issue, we do consider it important that a standard emergency distress call is implemented at all prisons.

We recommend that the Department implement a standard emergency distress call with expediency.

In response to the Draft Report, the Department said:

"Implementation of a standard emergency distress call will be referred to the Prison Services Operations Group for an action."

(i) Post-incident Support

In accordance with PPM E.08 (Operational debriefing as a result of Incident), all staff involved in a serious incident are to attend a debriefing. The purpose of this is to provide staff involved in the incident the opportunity to discuss what happened, and to review the way the incident was handled. Part of the debrief is to ensure that staff are aware that support is available for any who are distressed.

(j) Do Not Resuscitate

The Code of Health and Disability Services Consumers' Rights 1996 it states that:

"Every consumer may use an advance directive in accordance with the 'common law' and every consumer has the right to refuse services and to withdraw consent to services."

The right to refuse medical treatment is also recognised in the New Zealand Bill of Rights Act 1990. Section 11 states that: *"Everyone has the right to refuse to undergo any medical treatment."* The right only arises where a person is competent to consent to treatment. Where a person is competent, treatment cannot be imposed on them without their consent.

"Advance directives" as referred to in the Code of Health and Disability Services Consumers' Rights are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity. A living will is one form of advance directive, leaving instructions for treatment. Another method authorises a specific type of power of attorney or healthcare proxy, where someone is appointed by the individual to make decisions on their behalf when they are incapacitated.

A Do Not Resuscitate (DNR) request is when a person does not wish to have any resuscitation interventions should they suffer from a cardiac or respiratory arrest. A DNR is a written order completed by a doctor which is placed on a person's medical file should a cardiac or respiratory arrest occur.

The then Health and Disability Commissioner Ron Paterson at *"The Changing Minds Conference"* in Wellington in 2007 said that Not For Resuscitation or Do Not Resuscitate orders are much more common in practice than living wills or powers of attorney.

Mr Paterson said that:

"A doctor is able to place a note in a patient's records that based on an overall assessment of the patient's best interests, the patient is Not For Resuscitation. Usually what is intended is that cardio-pulmonary resuscitation not be administered in the event that the patient has a cardiac arrest while in hospital."

The Department does not have a policy in relation to the development and implementation of DNR orders in respect of prisoners. Currently, all prisoners receive resuscitation interventions by either custodial staff or nursing staff. A DNR order will not be followed by any staff member in Prison Services.

Our view is that prisoners must retain their medico-legal rights regarding end-of-life decisions, and should not have such rights diminished or obstructed. Failure to allow such rights would be unreasonable or wrong.

We recommend that the Department respect a Do Not Resuscitate policy, if this is prisoner-initiated and ensure that these requests are properly documented.

In its response to the Draft Report, the Department said:

"An End of Life Policy is being developed in conjunction with the Ministry of Health, which will include consideration of Do Not Resuscitate orders."

Chapter 9 - HEALTH PROMOTION AND PREVENTATIVE STRATEGIES

Public Health and Preventative Services are based on a “*whole population basis*” including (but not limited to) immunisation, diabetes, cardiovascular disease and smoking cessation.

The Department is not funded to provide Public Health and Preventative Services - this is the responsibility of the Ministry of Health. The Ministry directly funds public health units within DHBs (as well as Non-Governmental Organisations) and contracts the provision of services from those units. Services include public health providers such as the Mental Health Foundation and the NZ Aids Foundation.

Health promotions such as smoking cessation and cancer awareness are offered to prisoners by Health Services staff at some prisons. They usually run in parallel to what is happening in the general community, but they are limited in their scope. Health Centres we visited had a range of pamphlets and information available for prisoners to read regarding a range of health topics. However, there was very little evidence that health promotion was taking place at a wing or unit level.

Health promotion can build the physical, mental and social health of prisoners and staff, prevent the deterioration of a prisoner’s health during or because of custody, and encourage prisoners to adopt healthy behaviours which can then be carried back into the community.

A Ministry of Health Report (2007) concerning the options for funding and delivering health services for offenders showed that in a stocktake of public health services provided by DHBs to prisons, one-third of DHBs were not providing any health protection or promotion services at all, with an inconsistent range of services provided by other DHBs. This view accorded with the comments of Health Services staff who said there was little involvement from DHBs in respect of health programmes for prisoners.

Particular occurrences provide an opportunity for Health Services to actively engage with prisoners. For example, during an outbreak of scabies, instructions on the proper laundering of bedding and how to prevent re-infection could have proven worthwhile. This type of response, however, is very much dependent on the time Health Services staff have to organise and run such activities while performing their regular duties.

We were told of an instance where Health Services staff wished to distribute information to prisoners regarding testicular cancer. The depiction of male self-examination was considered by the prison manager as inappropriate due to its sexual nature and the promotion did not go ahead. We suggest that this type of issue should be considered as part of national policy, and not decided on a local basis. Consideration should be given to the identification of any barriers, either perceived or real, that discourage health education in prisons; and the development of a national policy on health education for prisoners.

Chapter 10 - EXTERNAL HEALTH SERVICES

(a) Memorandum of Understanding between the Department of Corrections and Ministry of Health

In 2004 a Memorandum of Understanding between the Department and the Ministry of Health came into effect. The memorandum had its genesis during 2001 when the Department and the Ministry worked together in relation to a number of health issues affecting prisoners. This included technical assistance on substance abuse, Hepatitis B screening, the control of tuberculosis and other communicable diseases and the development of service specifications for prison health and disability support services.

Common issues were identified and it was decided to establish a joint working group to examine how these issues might be addressed.

The purpose of the Memorandum of Understanding is to define the roles and responsibilities of the Ministry and the Department in those areas where the two agencies have complementary responsibilities for protecting and enhancing the health status of prisoners. It is also to facilitate co-operation between the two parties with the development of strategy, policy, and communications in areas that have the potential to affect the parties' abilities to enhance the health status of prisoners.

An extract from the general guidelines of the Memorandum is attached at **Annex 3**.

We note:

- a) *that the principles underpinning the memorandum include:*
 - "2.1 *The health needs of prison inmates should be effectively monitored and managed..."; and*
- b) *that the desired outcomes of memorandum include:*
 - "4.1.1 *Health services are to be made available for prison inmates at a level commensurate to that available to the general population of New Zealand.*
 - 4.1.2 *The health services to be provided to prison inmates will be the same standard as is provided to the general population of New Zealand."*

We endorse the preceding principles.

We also endorse the sentiment of section 5.19 which reads:

"5.19 Prison inmates will be subject to the same Clinical Priority Access Criteria for publicly funded elective services as the general population..."

The above is consistent with the United Nations Standard Minimum Rules for the Treatment of Prisoners rule 22(1) of which states:

"22(1)...The medical services should be organised in close relationship to the general health administration of the community or nation..."

(b) Drug and Alcohol Assessments

District Health Boards fund Regional Community Alcohol and Other Drug Services (CADS) to provide services to prisoners with alcohol and drug problems.

In the Southern Prison Region, CADS currently provide Alcohol and Other Drug (AOD) assessments for prisoners six months before their release date. In the Northern Prison Region, CADS provide reports only for released offenders.

In the Central Prison Region, CADS do not generally provide services beyond Methadone support. Should the Parole Board request an AOD report, the prison's social worker will usually arrange this via a recognised AOD provider. Reports are completed at a cost to the Department.

In the Southern Prison Region, CADS had, until June 2009, provided Alcohol and Drug assessments free of charge for prisoners within six months of their statutory release date. This is because the assessment reports would be valid for residential treatment or other treatment at the time of the prisoner's release. Assessments outside the six month period before release and requested by the New Zealand Parole Board were paid for by the Department.

However, in June 2009, CADS was notified by the Regional Prisoner Services Manager (Southern Region) that, due to the current scrutiny on Government Department spending, he was no longer in a position to fund any costs associated with CADS assessments, *"irrespective of whether they have been requested by the New Zealand Parole Board"*.

We are aware that the Parole Board in the Southern Region had requested the completion of CADS assessment reports for the next scheduled hearing dates of prisoners, only to find that its requests had been disregarded. We are not in a position to say such disregard has had an adverse effect on the granting of parole, but that possibility is a concern.

We urged the Department to give due impetus to resolving this current impasse with CADS in the Southern Region. In our view, an AOD report requested by the Parole Board should be provided irrespective of a prisoner's release date, or the cost of such a report.

In August 2011, the Department advised us that the Canterbury District Health Board has now allocated funding to allow for the provision of additional CADS assessments for the Parole Board for those prisoners who are more than six months away from their statutory release date.

We are pleased that the earlier impasse has been resolved.

(c) Physiotherapy, Podiatry and other services

On-site physiotherapy services are provided for prisoners at Auckland Region Women's Corrections Facility, Spring Hill Corrections Facility, Auckland Prison, Auckland Central Remand Prison, Waikeria, Hawkes Bay and Whanganui Prison and all prisons in the Southern Region.

For prisons without the services of a physiotherapist on-site, Health Services make an appointment with a local provider and prisoners are taken there under escort.

Prisoners can have their basic vision checked at any time by a prison nurse. Should fuller assessment be required, an appointment with an ophthalmologist will be arranged by Health Services staff.

At women's prisons, regular cervical smear clinics are available to prisoners. Health Services staff said sexual health issues are often raised by prisoners at this time. Female prisoners who require a cervical smear have a recall date that appears automatically on MedTech. The required date for this information is sought from either the prisoner, the prisoner's General Practitioner, or the cervical screening programme she previously attended.

Health Services arrange for prisoners to be taken off-site for mammograms at Breastscreen Aotearoa. This is either as a result of a Medical Officer's referral, or as part of the regular breast screening process. Free breast screening is offered to New Zealand women aged 45 to 69 years.

At Auckland Region Women's Corrections Facility, Health Services cannot have the services of a Breastscreen Aotearoa mammography mobile unit due to the small number of prisoners requesting this service. Instead, prisoners are sent off-site to the Counties-Manukau Screening Programme.

In the main, prisons do not have x-ray machines. With the exception of the Northern Region Corrections Facility, a mobile x-ray service visits all other sites in the Northern Region. Prisoners who require an x-ray at all other prisons are escorted to hospital.

The Department advised us that, if clinically indicated, referral to a chiropractor is made by a Medical Officer or occasionally a nurse.

Some prisons are particularly well serviced by the type of external Health Services they are able to provide.

For example, Waikeria Prison has, along with Mental Health Services, the services of:

- an occupational therapist;
- an alcohol and drug counsellor;
- a gastroenterology team from the Waikato Public Hospital;
- a diabetic resource nurse from the Waikato Public Hospital;
- a physiotherapist;
- Child and Adolescent Mental Health;
- a retinopathy outreach programme for diabetics;
- a hepatitis resource specialist nurse;
- ACC staff for regular follow-up for paraplegic prisoners;
- Disability Resource Limited for assessment of Waikeria Prison's aged population; and
- a stoma nurse from the Waikato Public Hospital.

Hawkes Bay Regional Prison has the services of:

- a continence advisor;
- a urology case co-ordinator;
- a wound care specialist;
- a specialist hand therapist;

- a podiatrist;
- an occupational therapist; and
- ACC assessors who assess the need for ACC-funded carers to help with daily cares. For example, care provided for paraplegics.

Our investigation indicated that prisoners have reasonable access to physiotherapy, podiatry and other services.

(d) Third Party Health Providers

There is a range of other agencies and organisations that provide Health Services to prisoners. These include non-state-funded agencies such as Te Oranganui Iwi Health Authority, which provides AOD services at Whanganui Prison.

Those and other agencies provide valuable services to help meet the health needs of prisoners.

(e) Regional Forensic Psychiatry Services

Our investigation is in relation to the Department of Corrections, and therefore the administrative processes of Regional Forensic Psychiatry Services (which are funded ultimately by the Ministry of Health via DHBs) are outside the ambit of this investigation. Nevertheless, the contribution of Regional Forensic Psychiatry Services forms an integral part of the way in which prisoners are managed by the Department. The comments below are intended to reflect the involvement of Regional Forensic Psychiatry Services in the management and care of prisoners with mental illness.

The establishment of Regional Forensic Psychiatry Services in New Zealand was made in response to issues raised in the Mason Report, which presented the findings of the *“Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in relation to Admissions, Discharge or Release on Leave of Certain Classes of Patients”* in 1989.

Six regional forensic facilities were built and commissioned, the first one being Te Whare Manaaki (Hillmorton Hospital) in Christchurch in 1999. Five other facilities were commissioned in Otago, Auckland, Wellington, Hamilton and Whanganui.

Prior to the establishment of Regional Forensic Psychiatry Services, the care of psychiatric and psychopaedic patients had been “institutionalised care” at hospitals such as Sunnyside, Lake Alice and Tokanui. “Psychopaedic”, a term unique to New Zealand, was coined in the early 1960s by Dr Blake-Palmer, the Director of Mental Health, in an attempt to distinguish those who were mentally ill from people with an intellectual disability.

In 1986, the Department of Health published its *“Review of Psychiatric Hospitals and Hospitals for the Intellectually Handicapped”* report for the then Minister of Health, Dr Michael Bassett. The Review stated: *“Major and important changes have occurred in the philosophy and techniques of treatment and care of the psychiatrically disabled and intellectually handicapped; and an increased awareness has developed, worldwide, of the needs for new standards to be applied to the care of such patients”*.

In the 1990s, Government policy saw the deinstitutionalisation of state institutions for both the psychiatrically and intellectually disabled in favour of community care.

The success of Government policy over this time remains a controversial issue.

In 1992, the Mental Health (Compulsory Assessment and Treatment) Act was passed to *“redefine the circumstances ... and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment”*, as evidenced by a new definition of “mental disorder” which established the modern threshold for compulsory treatment.

The meaning of mental illness in terms of mental abnormality, rather than social deviance, resulted in the release of 37 potentially dangerous offenders held in psychiatric hospitals into the community in 1993.

The role of Regional Forensic Psychiatry Services is to assess, treat and rehabilitate people with a mental illness who had, or were alleged to have, committed a crime and those who were likely to offend. Forensic Services provides prisons with specialist services, arranges for the transfer of mentally ill prisoners to medium secure hospital facilities when necessary, and provides consultation, liaison and support services for prison staff. Psychiatric nurses and visiting psychiatrists, employed by Regional Forensic Mental Health Services, provide secondary mental healthcare in the prison setting.

Prisoner access to Regional Forensic Psychiatry Services is based on referrals from Health Services nurses and Medical Officers. Application is usually made under the Mental Health (Compulsory Assessment and Treatment) Act 1992 when there are reasonable grounds to believe that a person may be mentally disordered. Applications under the Act require the inclusion of a medical certificate from a medical practitioner who has examined the prisoner within the preceding three days. The assessment examination of a prisoner referred to Regional Forensic Psychiatry Services must take place at prison within 48 hours of the application being received or, if that is not practicable, in a hospital within 72 hours of receipt of application. We are satisfied with the Department’s referral process that ensures prisoners are assessed by Regional Forensic Psychiatry Services staff.

The Government’s National Mental Health Strategy requires that mental health services be delivered to the 3% of the population who are most severely affected by mental illness. All mental health services must give priority to this group of people with respect to access to services, within the resources available.

In *“Blueprint for Mental Health Services in New Zealand”* 1998, the Mental Health Commission said:

“The Strategy requires mental health services to be delivered to the 3% of the population who at any given time are most severely affected by mental illness. The development of this percentage was done primarily for national and regional planning, and any translation of these figures for requirements at a local level must take into account the local population and its needs.”

The Health Funding Authority was disestablished in 2000, when the planning and funding of most taxpayer-funded health services shifted to 21 District Health Boards, and some to the Ministry of Health.

A protocol established between the Department and Ministry of Health (annex 4) outlines the expectations of both parties regarding the management of prisoners requiring secondary mental health services and hospital level care.

Appendix 7 of the Memorandum sets out guidelines for Mental Health Services to prisoners. The following principles guide the provision of services by forensic mental healthcare for prisoners:

1. prisoners' need for mental healthcare should govern their access to services;
2. prisoners should be accommodated in facilities that match their need;
3. prisons are not the most appropriate environment to assess and treat acutely mentally unwell prisoners;
4. prisoners cannot be subject to compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 in prison;
5. every effort should be made for prisoners to be able to receive a level of care that is reasonably equivalent to that available in the general population; and
6. Prison Services are funded only to the primary health level.

Prison Services only have a duty under the Corrections legislation to provide necessary health services to prisoners. The Corrections legislation and health legislation require that the provision of secondary and tertiary health services (including secondary mental health services) are the duty of District Health Boards.

It would seem that Regional Forensic Psychiatry Services provide specialist mental health services to the prison population at a level that is similar to that provided by mental health services in the community. That said, the prison community cannot be easily compared with the general community. Prisoners represent a concentrated population group with high frequency needs.

Due to the lack of available secure forensic beds and the high level of need both in prison and in the community, Regional Forensic Psychiatry Services cannot always provide a bed for a prisoner with an identified need for inpatient assessment and/or treatment at the time the need is identified. Our understanding is that inpatient facilities average 100% occupancy. The Mason Clinic in Auckland, for example, has 95 secure beds, but only 15 are available for acute admissions. If there is no bed available for a prisoner who is required to undergo assessment or treatment at a forensic unit, the prisoner is waitlisted until one becomes available. The result is that seriously disturbed prisoners remain in prison until a bed becomes available. Much of the problem of waiting lists is that prison musters have doubled in the last 10 years, whilst the resources of forensic mental health and available beds has by no means increased to the same extent.

Mentally unwell prisoners often have tendencies of violence towards others and/or self-harm. Holding such prisoners in a purely custodial environment appears to result in inappropriate risk for both the prisoners themselves, and those around them. From our own knowledge, we can say that the Department's non-medical staff are often called upon to deal with extremes of irrational behaviour resulting from mental unwellness.

We have expressed our considerable concern about this in successive annual reports. In our view, the risks to prisoners and staff alike are unacceptably high. There is continued inertia across health and custodial services to resolve issues ranging from the provision of adequate numbers of forensic beds to legislative definitions of what constitutes mental health/behavioural disorders.

As a consequence, we intend to investigate and report separately on the management of mentally unwell prisoners within the Corrections system.

Chapter 11 - CONTRACTED MEDICAL OFFICERS

Medical Officers are contracted to the Department to provide medical services to prisoners. Medical Officers are expected to provide services to a standard satisfactory to the Department, and to conform to all the laws and customs applicable to the medical profession in the provision of those services.

Regional Health Centre Managers in consultation with Health Centre Managers are responsible for ensuring that Medical Officers fulfil the obligations contained in their contracts.

Medical Officers must be registered with the Medical Council of New Zealand. Registration is the means by which the Council achieves its primary purpose to ensure that medical practitioners are fit to practise. The Medical Council operates under the Health Practitioners Competence Assurance Act 2003.

Section 20 of the Corrections Act 2004 provides for Medical Officers. It states:

- (1) *For every prison (other than a Police jail), there must be 1 or more medical officers responsible for providing medical care and medical treatment to prisoners.*
- (2) *Each medical officer must be a medical practitioner.*
- (3) *Every medical officer must –*
 - (a) *be appointed or engaged under section 11(1)(b), (2)(b), or (4) or*
 - (b) *carry out his or her functions in accordance with arrangements approved by the chief executive.*

Section 11(1)(b), (2)(b) and (4) relate to the appointment and responsibilities of prison managers and other staff. The chief executive means the Chief Executive of the Department of Corrections.

According to the Corrections Act, the function of each Medical Officer is to provide medical care and medical treatment to prisoners. However, the Corrections Regulations 2005 go further.

Regulation 73(1) states:

“A medical officer of a prison must take all practicable steps to maintain the physical and mental health of prisoners to a satisfactory standard.”

Our impression is that, it is prison nurses, rather than Medical Officers, who take the principal role in maintaining the day to day physical and mental health of prisoners. The Corrections Administration (Effectiveness and Efficiency) Bill presently before Parliament also recognises this.

The Bill recognises that, in reality, prison Health Centre Managers employed by the Department have the central role of ensuring that the health needs of prisoners are met. Current legislative provisions place contracted Medical Officers at the forefront of the provision of Health Services to prisoners. The Bill proposes that this role should be a function of the Health Centre Manager. We have had the opportunity to comment on this, and other health-related amendments proposed in the Bill.

Article 22(1) of the United Nations Standard Minimum Rules (UNSMR) for the Treatment of Prisoners states:

"At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry."

Medical Officers are usually General Practitioners and, in general practice, they would most likely have experience of only treating people who suffer from depression, anxiety and phobias.

UNSMR 25(1) states:

"The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed."

In New Zealand prisons there is no daily on-site coverage by a Medical Officer. However, nurses provide daily coverage generally up until 9.00pm. Medical Officers can be contacted by telephone after this time.

We observe that, Medical Officers, in the main, work jointly with Health Services staff. Broader custodial issues are primarily outside the general knowledge of Medical Officers, unless there are apparent issues involving the custodial management of certain prisoners and how these might impact on prisoners' health.

At one of the smaller prisons we visited, Health Services staff commented positively regarding their ease of contact with Medical Officers after hours, the care they afforded prisoners and the additional hours Medical Officers work in excess of those contracted.

This was not the case at all prisons we visited. At some sites, Health Services and custodial staff expressed concern about the limited hours and quality of the service provided by the Medical Officer at their prison.

The Department might consider periodic review of coverage and standards of performance by Medical officers.

Chapter 12 - DENTAL AND ORAL HEALTH

The Prisoner Health Survey 2005 was a national survey of sentenced prisoners developed by the Ministry of Health and conducted by the National Bureau of Research. Face-to-face interviews were conducted with prisoners from May to December 2005 using a questionnaire mainly developed from the 2002/2003 New Zealand Health Survey and the New South Wales Inmate Survey from Australia.

The survey provided valuable information on prisoners' oral health. Key points highlighted in the survey included:

- one in three prisoners reported having toothache in the last four weeks;
- nearly half of all prisoners reported experiencing tooth or mouth discomfort in the last four weeks;
- three out of ten prisoners reported an improvement in dental health compared to two years ago; and
- one in four reported a decline in dental health compared to two years ago.

Prisoners have high dental health needs, possibly caused by increased levels of neglect of oral care, high rates of substance abuse, smoking and underlying poor nutrition. Prisoners vary in their ability and motivation to take care of their own oral health, often entering prison with a previously chaotic lifestyle. A nurse used the term "drug teeth", which is connected to unlawful drug use. Long-term dental pain has the causal effect of contributing to a general decline in health.

The prison environment can present challenges and impose limitations on how dental services are managed and delivered. Sessions can be shortened by security procedures or general lockdowns. Our Investigator was told:

"Unfortunately all prisoners booked for that day were cancelled as the dentist was unavailable. Not long after that the dentist decided not to renew his contract and so the tender process began. This process took longer than expected therefore creating longer waiting lists."

Dental services for prisoners 18 years and under are the responsibility of the Ministry of Health. These services are funded by District Health Boards under Adolescent Oral Health Services. Services may include diagnosis and advice, radiographs, restorations, extractions and prosthesis.

The funding and provision of dental treatment services for prisoners over 18 years of age is the responsibility of the Department, and is provided by Prison Services which contracts external dentists to provide treatment.

The Corrections Act 2004 does not provide specifically for prisoner dental care, but rather it refers to the general provision of medical care under which dental care is considered.

The provision of dental services is found in the Corrections Regulations 2005. In relation to dental services, regulation 81 states:

1. *The chief executive must ensure that –*
 - a) *dental examinations, and any other dental treatment approved by a medical officer, are provided for prisoners free of charge to them; and*
 - b) *a dentist is available to provide the examinations and treatment.*
2. *Any examination or treatment must be primarily concerned with the relief of pain, the maintenance of a reasonable standard of dental care relative to the dental and oral health of the prisoner concerned before the prisoner was admitted to the prison, or both.*
3. *Subclause (1) is subject to subclause (2).*
4. *In this regulation, dentist means a person for the time being registered as a dentist under the Health Practitioners Competence Assurance Act 2003.*

The minimum dental services policy requires “prompt pain relief” to all prisoners. Pain relief may include medication, extraction, dressing or drainage of an abscess from the tooth.

Under the minimal dental services policy, prisoners detained for more than one year will receive general dental care, provided they have taken prior responsibility for their own dental care. The prison dentist is the sole judge of what constitutes previous dental responsibility, based upon his/her professional judgement.

For those showing previous dental responsibility free services include:

1. Provision of single or multi-surface metallic or non metallic restorations, i.e. amalgams, composite of glass ionomer restorations only;
2. Treatment of acute and chronic periodontal disease;
3. Root canal treatment of anterior teeth only;
4. Extractions where appropriate;
5. Minor oral surgical operations, including the removal of impacted 3rd molars;
6. An annual oral assessment at prisoner’s request. The prisoner is required to have a long sentence and have shown previous dental responsibility; and
7. Other appropriate treatment as required.

Treatment exceptions usually include; orthodontic treatment, crown, bridge, and implant treatments. However, if prisoners can pay for the particular treatment themselves or treatment is covered by ACC, the treatment will be carried out.

For those showing no previous dental responsibility, free services include:

1. relief of pain only, i.e. dressing and/or extraction.
2. treatment of acute periodontal conditions.
3. other appropriate treatment as required.

Prisoners detained for less than one year will receive:

1. relief of pain only; or
2. other appropriate treatment as required.

Dental treatment for prisoners is usually delivered at a prison but, where appropriate facilities are not available, treatment will be provided at a dentist's private practice premises or at another prison. At Arohata Women's Prison, for example, women prisoners are escorted to the dentistry facility at Rimutaka Prison once a fortnight. This does, however, necessitate the closure of the Rimutaka Health Centre for prisoner consultations because women prisoners cannot mix with male prisoners.

Prisoners at Tongariro/Rangipo Prison, New Plymouth Prison, Invercargill Prison, Rolleston Prison, Christchurch Women's Prison and Wellington Prison are escorted to a dentist off-site.

Some prisons have, or have had, difficulty in securing the services of a dentist. In recent times, a Wellington dentist was flown to Christchurch to provide dental care for prisoners at the three Canterbury prisons. Other sites have seen a reduction in services provided. At Invercargill Prison, for example, at the time of our inquiries dental services had been reduced from 4 hours per week to 2.5 hours.

The high turnover of prisoners in some prisons can act as a barrier to effective dental care, and there can be conflicting demands for "unrealistic" or "inappropriate" treatments ranging from opiate pain relief to cosmetic dentistry. We receive some complaints from prisoners concerning the refusal of the prison dentist to undertake dental work because they are "too close" to release.

A prisoner at Hawkes Bay Regional Prison said:

"I put in a chit to see a nurse about my tooth, it was discoloured and decayed. She declined to put me on the dentist's list. Some months later, I saw the nurse again because my tooth was sore at night. She told me to take Panadol. My tooth finally abscessed and when I saw the nurse I was told because I was getting out soon I needed to see a dentist then."

Another prisoner suffering from toothache told us he was advised by Health Services that his request to see the prison dentist had been declined, and he was also advised to take paracetamol. His tooth abscessed and he claimed he was in great pain. He was also told to see the dentist when he was released.

We appreciate that dentists' hours are limited. However, the refusal to provide urgent dental care simply because a prisoner is due for release is unreasonable in the circumstances of a case such as this.

Very few prisoners we spoke to commented favourably in respect to dental services. At the prisons we visited, prisoners regularly complained about delays in dental treatment. Not only did they complain about suffering pain during such delay, but referred to additional dental problems such as infection and abscess by reason of the delay.

The frustration of some prisoners is exemplified by a prisoner who told our Investigator that he had been in prison for two months. At his reception into prison he went through the initial medical check, where he made it known that he had a cavity in his tooth and that he needed to see a dentist. He thought at this point it was noted on his medical records as urgent. Since the time of his reception he had received no treatment apart from paracetamol. The prisoner went on to add that his jaw ached, his glands were swollen and he had a sore ear.

The prisoner put in numerous requests to see Health Services and claimed he had been told by the nurse that there were prisoners who have been in prison longer, and he would have to wait to see the dentist.

When the prisoner's complaint was followed up by our Investigator, he was told by the Health Centre Manager:

"This man is on the dental waiting list, at present there are 52 on the list and he is sitting at number 33. Each week the Dental Portfolio Nurse triages each prisoner on the dental list and places the most urgent cases in front of the Dentist. It is unlikely that this man will be seen by the Dentist until 2-3 weeks, depending on his clinical presentation. He is able to see a nurse at any time for further dental assessment and pain relief and he is aware of the correct process to follow in regards to this."

It was pleasing to note that this prisoner had been placed on an appointment list to see the dentist. However, a 2 or 3 week wait before treatment is, in our view, unreasonable.

At another prison, a Team Leader (Health) told us that 38 prisoners were currently waitlisted to see the dentist and this was, for some, a 3-month wait for an appointment. The dentist is only contracted to work two sessions per week and, while we were advised by the Health Centre Manager that urgent dental problems would be dealt with, a large number of prisoners' dental problems still lay unattended for a long time.

In relation to another prisoner's complaint we were told that *"his request has been triaged along with the other 40 inmates waiting for dental care"*. This number represented a third of the total prisoner population (120 prisoners) at that prison waiting to see the dentist.

We were advised at a further prison that the waitlist for urgent care was 2 weeks, semi-urgent care 3 months and non-urgent care more than 3 months. At yet a further prison the waitlist, with the exception of emergency treatment, was 6 weeks due to the dentist being overseas for a month.

For members of the general public emergency dental needs can usually be readily met, although a 2-week wait would, to most people, be unacceptable.

The length of waitlists for prisoners requiring dental treatment indicates a failure to meet the Department's Performance Standard B.06 (Dental Care) that states: *"the dentist's practice hours are adequate to meet the prescribed minimum dental services for each prisoner"*. It would appear that the dental service is not being resourced at a level which reflects the high levels of dental need which exist in New Zealand prisons.

We refer again to Regulation 81 (2) of the Corrections Regulation 2005 which states:

"Any examination or treatment must be primarily concerned with the relief of pain, the maintenance of a reasonable standard of dental care relative to the dental and oral health of the prisoner concerned before the prisoner was admitted to the prison, or both."

Examination or treatment based on previous dental care does imply a "deserving" versus a "non-deserving" model of care, although we appreciate the need for a criterion to determine the level of minimal care and treatment provided.

The Ombudsmen's report in relation to the Detention and Treatment of Prisoners in 2005 stated:

"We appreciate that there could be concern by the public that prisoners receive better dental care than can be afforded by many free persons in the community. Nevertheless, it seems to us regrettable in a society such as New Zealand that a person deprived of their liberty can suffer needless dental deterioration while in the care of the State. There is certainly a balance to be struck between adequate and inadequate care. At the moment, we consider that the principle of "duty of care" imposed on the Department is absent and the balance is on the side of inadequacy."

The situation does not appear to have improved since the publication of Ombudsmen's 2005 report.

Historical trends have, according to the Department, enabled Health Centres to determine the number of hours dental clinics are required to run at each health centre.

The Department said: *"Demand fluctuates, but generally the hours budgeted for provide sufficient for demand"*.

It appears the Department considers its policy and delivery of dental services to be satisfactory. Nevertheless, our investigation has revealed that a significant number of prisoners are not receiving a standard of dental care because of delay, that, in our view, should not be expected in a modern society such as New Zealand. This, in our view, is unreasonable and wrong.

We recommend that the Department consider expansion of the current dental service to reduce the length of time prisoners wait until they receive dental treatment.

In its response to the Draft Report, the Department said:

"The Department will audit current waiting list times for prisoners to access dental services in order to identify areas of concern."

Chapter 13 - CUSTODIAL SUPPORT FOR HEALTH SERVICES

(a) General Comment

The relationship between custodial staff and Health Services staff varied considerably between prisons. From what we were told, it would appear that an uncooperative relationship between Health Services and custodial staff existed at some prisons. At others, positive relationships have been established.

A prison Chaplain, with many years' experience, within the Department, said the focus of the Department is custodial and Health Services are, at best, *"tolerated"*, rather than being accepted as an important aspect of the Department's work.

The difficulties some Health Services staff experience are manifested in different ways.

Health Services staff considered that custodial staff did not support them or intercede when prisoners became demanding, especially during medication rounds. A Health Centre Manager remarked that: *"(Custodial) staff are not always supportive. Custody want the prisoner to get a good outcome"*. This was acknowledged by a prison manager who said: *"Custodial staff need to step in more regarding abuse. Custodial staff are blasé"*.

It appeared to some Health Services staff that they had to serve an apprenticeship or probation period in order to demonstrate to custodial staff that they could indeed work in a prison environment.

A Health Centre Manager told us that she experienced hindrance in obtaining the use of a small office in the prison's Receiving Office to enable nurses to assess prisoners' health needs at the time of reception. Up until the time Health Services staff had access to the office, nurses were expected to undertake assessments in holding cells. This afforded nurses and prisoners little privacy. The Health Centre Manager's concern was that it had been difficult to obtain custodial approval to use an otherwise unused office.

Conversely, custodial staff expressed concern regarding Health Services staff. A Principal Corrections Officer (PCO) said:

"Nursing staff don't see prisoners when promised and sometimes nurses forget custodial issues."

Another PCO said:

"A prisoner was promised eardrops, but the nurse went on leave and he did not receive the drops. When staff contacted the Health Centre, no-one knew anything about it."

Furthermore the same PCO said:

"Nurses are inconsistent with medication. One will give (prisoners) Ibuprofen while others won't."

A prison manager raised a question about the calibre of nursing staff when he said:

"We had a nurse who started last week but she didn't even know how to take blood pressure."

A unit manager took a rather disparaging view of Health Services staff when she said:

"A prisoner in the unit burnt his foot and asked to see the nurse. Custodial staff contacted the nurse and explained the situation. The nurse said tersely 'no - I will see him tomorrow.'"

When custodial staff inquired about him being seen by Health Services staff the following day, they were informed that the prisoner was not on the list to be seen.

The delivery of effective healthcare to prisoners is, we believe, dependent upon a good "partnership" between custodial and Health Services staff. Unfortunately, at some prisons such a "partnership" appeared lacking.

(b) Uncertainty Regarding Roles and Responsibilities

Any conflict between Health Services staff and custodial staff could have adverse consequences for prisoners. At prisons we visited it was clear to us that the roles and responsibilities of Health Services staff and custodial staff were sometimes blurred.

It was evidenced in a number of ways, from seemingly trivial matters to potentially serious incidents.

At the more trivial end, we were told about a prisoner with a sore neck who had been seen by the prison's Medical Officer and an additional pillow had been recommended. The recommendation had been sent to the Principal Corrections Officer in the unit where the prisoner was placed. The PCO inferred that the prisoner was simply "playing the system" and custodial staff would not provide him with another pillow.

Regulation 79 (1) of the Corrections Regulations 2005 states that:

"A registered health professional, a medical officer of a prison, or a staff member who is a nurse may make recommendations to any other staff members in respect of the health needs of prisoners."

Furthermore Regulation 79(2) states:

"In making any decision in respect of a prisoner, a staff member must consider all recommendations."

It thus appears that custodial staff are not obliged to accept a recommendation by a nurse or Medical Officer. Whether or not the Principal Corrections Officer had justification to take the stance she did, we do not know. However, her entitlement to do so seems to be at odds with section 20(1) of the Corrections Act 2004 that states:

"For every prison (other than a police jail), there must be 1 or more medical officers responsible for providing medical care and medical treatment to prisoners."

The line between medical care and treatment in section 75(1) of the Corrections Act 2004 and health needs in regulation 79(1) of the Corrections Regulations 2005 is not clear to us. In the example given, the recommendation for a pillow could fall in either category. We suggest that consideration be given to aligning more clearly the terms used in the regulations with that used in the Act.

An issue that involved access to health information was raised by a Health Centre Manager. She said on several occasions Health Services staff had come into conflict with custodial staff concerning the release of prisoners' medical files after deaths in custody. The Health Centre Manager said custodial staff entered the Health Centre and uplifted health files without permission from the Health Centre Manager.

In summary, therefore, in our opinion there appears to be uncertainty regarding the respective roles of Health Services staff and custodial staff.

We recommend that the Department require all prisons to develop Service Level Agreements that clearly establish the roles, responsibilities and expectations of Medical Officers, Health Services staff and custodial staff.

In its response to the Draft Report, the Department said:

"The current Health Services work plan identifies the need to develop appropriate guidelines for managing the relationship between Health Services and the wider Prison Service. Resources to progress this project at this stage have not been available. However, we expect that the project will be completed in the 2011/12 financial year."

(c) Transfers

According to Departmental figures, in the 2010-2011 financial year, there were 10,775 inter-prison transfers.

By virtue of section 53(1) of the Corrections Act, the Chief Executive of the Department has the legal mandate to transfer prisoners. Section 53(1) states:

"A prisoner may be transferred, on the direction of the chief executive, from one prison to another in which he or she may be lawfully detained."

The Department's prisoner transfer policy is that prisoners are to be transferred safely, humanely and securely, with correct documentation and in accordance with their sentence plans.

Section 54 of the Corrections Act 2004 sets out available reasons for transfer, which include: to reduce the likelihood of reoffending, to place the prisoner in a prison closer to his or her family, to enable effective management of the national muster, and to ensure the safety of that prisoner or any other person.

Section 54(3) states:

"A prisoner may be transferred by the Chief Executive from one prison (the first prison) to another prison-

- (a) to restore or maintain the security and order of the first prison:*
- (b) to enable effective management of the national prisoner muster:*
- (c) to allow repairs or alterations at the first prison:*
- (d) in response to the closure or change of use of the first prison or part of that prison"*

Furthermore, the Department's policy performance standards require that:

1. *each prison has a selection process for identifying a prisoner's potential for transfer, which includes consideration of the prisoner's personal circumstances, current custodial status and sentence plan;*
2. *the Transferability Rating on IOMS is to be used for the above purpose; and*
3. *correct doses of prescribed medication for a prisoner are available during transit.*

We receive many complaints from prisoners who complain that their transfer was unreasonable. The Department's response is usually that the transfer was necessary for "muster management" purposes.

The Office of the Ombudsmen does not usually initiate a formal investigation of complaints regarding the transfer of prisoners, if preliminary inquiries show a likely reasonable exercise of discretion.

The transfer of prisoners is necessary to manage national muster levels. In the majority of cases, complaints from prisoners regarding their transfer to another prison are received after the transfer has taken place. In cases such as this, our practice is to inquire when it is likely the prisoner will be transferred back for a specialist medical appointment which had been made, and/or confirm that suitable medical arrangements have been made at the prisoner's new site.

Save for the most compelling reasons, we feel that prisoners should not be transferred immediately before a specialist health appointment.

More generally, our investigation has highlighted instances where prisoners have been transferred in circumstances where their health needs do not appear to have been given sufficient weight.

A regional prisoner transfer co-ordinator told us that it is a common occurrence for prisoners to be received who, because of their existing health problems, should not have been transferred.

A diabetic prisoner was transferred from Mt Eden Prison to Rimutaka Prison in November 2009. The last Medtech entry before his transfer states:

"bsl's levels (blood sugar levels) continue to be well elevated. Noted eye sight poor has difficulty getting blood onto stick? Need referring to diabetics clinic at GLH (Green lane Hospital) and there would have Samoan nurse etc to teach."

Health Centre staff at the prisoner's receiving institution said that the prisoner had no access to medication or water during his transfer from Mt Eden. On arrival at the prison, the Health Centre Manager said the prisoner's blood-sugar level was very high and he was transferred to hospital.

A fellow prisoner who was receiving weekly physiotherapy following extensive surgery was also transferred at the same time, with the result that treatment stopped.

Both prisoners were transferred under the Department's "muster management" category. In both cases, no health alert had been placed on IOMS to alert staff of the prisoner's current health status. (IOMS is the Department's computer offender database of information. Alerts are placed on a prisoner's individual file to alert staff of risk of escape, identified drug user status and identified health needs.)

A Team Leader (Health) at the prisoner's receiving prison said:

"There is no doubt that these prisoners should both be returned ASAP as this transfer is not in their medical best interests."

It would appear that prisons have little choice but to accept prisoners from other regions, when ideally they should not have been transferred due to health reasons. In an email to Health Centre Managers in the Southern Region, the Acting Regional Health Manager (Southern) said:

"These prisoners are being moved throughout the country and all prisons nationally will be expected to facilitate and manage this process. There is no flexibility for prisons to refuse to accept prisoners on health grounds."

In the two examples outlined above, refusal to take the prisoners may have been additionally detrimental to the prisoners' health, because they would have had another 13 hour trip back to Auckland from Wellington on the prison bus. As it was, arrangements were made for the prisoners to be transferred to Waikeria and Manawatu Prisons, prior to their return to Auckland.

A prisoner, under the care of a Regional Forensic Psychiatry Service, was transferred to another prison for muster management reasons. When the prisoner was advised of his impending transfer, he cut his wrist in an attempt to delay the transfer. The Department considered that there was no reason why the prisoner needed to stay at his present location and his psychiatric needs would be met by the Regional Forensic Psychiatry Service at his new region. This may well have been the case. However, in our view, the arbitrary transfer for muster reasons of prisoners receiving psychiatric intervention unnecessarily disrupts therapeutic relationships. The re-establishment of trust, rapport and collaboration by Psychiatry Services staff at a new prison may take a considerable period of time to achieve.

Another prisoner, also under the muster management category, was transferred at a crucial point in counselling. The prisoner was subject to forensic supervision and counselling and had reached a critical stage in working through a traumatic past event. It is our view that prisoners should begin and end counselling programmes with the same counsellor.

In accordance with departmental policy, a Medical Officer or registered nurse must advise the unit manager when a prisoner who has a scheduled Court appearance is medically unfit to attend.

Our view is that the transfer of prisoners with extensive health problems and/or who have been receiving intensive health services is unreasonable. The views of Health Services staff should be sought and assessed in respect of prisoners with a health alert on IOMS who are being considered for transfer.

We recommend that:

- 1. prisoners with a health alert on IOMS receive a health status clearance prior to transfer. This may include reviewing a prisoner's transfer in light of such things as counselling sessions or the input of extensive external health services;**
- 2. if a Health Centre Manager is of the view that a prisoner's health may be compromised by transfer or that his/her needs cannot be met in a timely manner after transfer to another prison, a recommendation that the prisoner be excluded from transfer be made to the prison manager; and**
- 3. the Department ensure that health alerts are placed on IOMS.**

In its response to the Draft Report, the Department said;

- “(1) The Healthcare Pathway Policy and Procedures (Section 12.5) describe the expectations when transferring prisoners between prisons. Health Services staff are expected to place a transferability constraint on the Transferability Rating Scale in IOMS if a prisoner should not be transferred for health reasons (including pending appointments with external specialist health providers).*
- (2) As above, and also Section 12.6 (Procedure for Transferring a Prisoner to another Prison) of the Healthcare Policy and Procedures.*
- (3) The Healthcare Pathway Policy and Procedures (Section 9) describe requirements for placement of health alerts on IOMS. Under this policy, the Regional Health Manager is responsible for making sure there are systems in place to ensure Health Alerts are achieved when required.”*

Section 12.6 Healthcare Policy and Procedures states that the custody staff member responsible for prisoner transfers should inform Health Services of a prisoner’s impending transfer. If Health Services staff are concerned about the prisoner’s transfer due to medical/health reasons, but the transfer is to proceed, then the decision must be escalated to the Health Centre Manager or Regional Health Manager (or both) for review.

Custody staff make the ultimate decision whether or not to transfer prisoners. However, it is our view that a prisoner should not be transferred against the recommendation of the Health Centre Manager or Regional Health Manager, save in exceptional circumstances. Should the Health Centre Manager or Regional Health Manager endorse the view that a transfer should not proceed on health/medical grounds, a recommendation to that effect, should be made directly to the Prison Manager. Any such recommendation would outline the health/medical reason(s) why the transfer should not proceed.

(d) Transferability Rating Index

The Department applies a transferability rating on each prisoner that it says allows easy identification of prisoners who can be transferred if necessary. The rating is used to minimise disruption to established offender plans. The transferability rating does not apply to transfers initiated by prisoners.

Transferability is rated from 1 to 4. Prisoners rated 1 are the first choice for transfer. Those rated 4 are least likely to be transferred. The rating is a guide only and circumstances may arise which mean that prisoners with a rating of 2, 3 or even 4 have to be transferred.

We note that of the 54 questions used to compile a prisoner’s transferability rating, only 3 refer to health matters. The health questions are as below:

Question 1: Does the inmate have an upcoming specialist medical appointment that can be changed?

Question 2: Does the inmate have a medical/psychiatric condition that precludes the inmate from transfer?

Question 53: Does the inmate have a medical appointment that can be changed?

A printout of prisoners at Hawkes Bay Regional Prison shows that of the 568 prisoners at the prison, only 2 had a "yes" answer in relation to health. Those were both in relation to question 2: *"does the inmate have a medical/psychiatric condition that precludes the inmate from transfer?"*

Examination of a printout from Whanganui Prison in 2010, showed that of the 476 prisoners, 12 obtained a "yes" answer in relation to questions 1, 2 and 53.

The exacerbation of prisoners' health problems on transfer, or the delay in obtaining treatment after transfer, are matters that require greater consideration by the Department. The Department may want to review the Transferability Rating Index with a view to considering the adequacy of the questions relating to prisoners' health.

(e) The Availability of Custodial Escorts

A major concern expressed by prisoners and Health Services staff related to medical escorts.

Any condition/injury requiring hospital attendance or a specialist consultation is reliant on the availability of custodial escort staff. For the 2009-2010 year, the Department said 4,354 prisoners were recorded as attending external appointments. This figure contains a mix of visits to hospital and other health professional premises. They are not separated out specifically. Hospital visits (i.e. a stay in hospital overnight) are separated out from external escorts. For the same year, 142 prisoners were admitted to hospital for a period of at least one night.

The frequency of medical escorts does sometimes place considerable demands on custodial staff. We are aware of scheduled medical appointments being cancelled due to staff unavailability.

Relatively minor injuries would appear to be a frequent source of attention requiring an off-site escort, as the examples below would indicate:

"Prisoner W informed staff that he had injured his foot whilst walking. Prisoner W was taken to medical, medical advised he would require an x-ray. Prisoner W was taken to hospital and returned the same day."

"Prisoner X informed staff that he required medical attention. Staff questioned him and he said he hurt his ankle whilst playing touch. He was seen by medical and an appointment was made for him to have an x-ray the next day (at hospital)."

"Prisoner Y informed staff that he had fallen whilst playing touch and his arm was really painful. Prisoner Y was seen by medical and required further assessment/treatment at hospital. Prisoner Y was taken to hospital and returned later that day."

"Prisoner Z informed staff that he had fallen whilst playing touch the day before and had injured his hand. Prisoner Y was seen by a nurse. Prisoner Y was taken to hospital for further assessment/ treatment. He returned later the same day."

Prison managers told us that the decision as to whether or not to send prisoners to hospital is the role of Health Services. This is as it should be. Prison managers told us they sometimes queried the absolute necessity that a prisoner be escorted to hospital, but the ultimate decision is that of a Health Centre Manager.

The Department's Health Service is essentially a primary care service. The Department may want to consider whether or not there is an opportunity to widen the scope of practice for prison nurses, or have recourse to expand the use of mobile x-ray machines to lessen the reliance on custodial staff for escorts.

(f) Health Training for Custodial Officers

We enquired into the syllabus topics covered by new custodial staff receiving their initial training staff at the Prison Officers Staff Training College based at Rimutaka Prison. The topics of study include, among other things, policy manuals, legislation, warrants, gang management and use of force. The only topics that relate to prisoner health are the 1st responder and suicide awareness modules.

As well as training to identify and respond to health concerns presented by prisoners, there is scope, we believe, to increase the understanding of custodial staff of the role and responsibilities of Health Services. The inclusion of Health Services as a separate syllabus topic for new Corrections Officers would help in this regard.

We recommend that the role and responsibilities of Health Services be included as a separate syllabus topic taught to new Corrections Officers.

In its response to the Draft Report, the Department said:

"The Department will consider inclusion of the roles and responsibilities of Health Services in the Initial Training Course."

(g) Special Diets

The Department provides approved diets for prisoners having a medical condition which necessitates dietary control or treatment. A medical diet is prescribed by a Medical Officer or registered nurse. When required, a registered dietician is consulted. Catering staff then prepare the recommended diet. The provision of diets based on a lifestyle preference (not medically necessary), or for religious or cultural reasons, are arranged by custodial staff. At times, confusion arises as to whose responsibility it is to provide such diets - Health Services or custodial staff.

The approval of medical diets is the responsibility of Health Services, but it is the responsibility of Corrections Inmate Employment (CIE) catering staff to prepare the required diet and for custodial staff to ensure that the recommended diet is given to the correct prisoner.

We were told by a prisoner whose medication caused constipation that the Medical Officer arranged for him to receive bran flakes from the prison kitchen. He was advised to take 3 tablespoons a day and, at that rate, the prisoner said his allocation lasted about a week.

At a later time, kitchen staff advised the prisoner that they had to cut down on expenses and therefore, the bran provided would have to last him a month. He said at that rate, he could only take a teaspoon a day. This amount was insufficient to control his condition and he became constipated again.

In this particular case, the prisoner was provided with bran from the kitchen. It was not a specific diet as such, but rather a medical supplement. Any intended change to a previously approved special diet or dietary supplement should, in our view, be discussed with a Medical Officer or the Health Centre Manager.

Prisoners continue to complain that the national menus implemented by the Department do not consider the specific health needs of prisoners, especially diabetics. Standardised menus were implemented by the Department in 2002. They were trialled by prisoners, and approved by nutritionists and dieticians as meeting the daily nutritional needs of adult New Zealanders. Apart from the standard menus for male and female prisoners, the menus incorporate dietary requirements for those who require a soft diet or low fat diet, and for those who are diabetic.

In 2009, the Department undertook a review of the national menus. The review analysed the four-week cycle of menus including energy levels and the number of servings from each food group. Work party rations, as supplied to prisoner work parties, were also reviewed; with particular focus on the activity levels and ranges of work types and industries employing prisoners across all departmental sectors.

As a result of the review, it was decided to combine the standard menu with the diabetic/low fat menu with the following exceptions:

- a) Artificial sweeteners used for prisoners with diabetes;
- b) Use of reduced fat mayonnaise, cheese and vegetable oils;
- c) Cooking methods will only include baking, grilling, boiling and steaming;
- d) Meat must be trimmed of fat, and skin removed off chicken; and
- e) Where sausages are served, these will be chicken sausages for prisoners assigned a diabetic or low fat menu.

Insulin-dependent diabetic prisoners also receive two Arrowroot biscuits daily, one extra serve of fresh fruit with the evening meal, artificial sweetener (instead of sugar), chicken sausages where sausages are stated on the menu, and cooking methods include baking, grilling, boiling and steaming only.

The Department said that dieticians' findings confirmed that overall the menus provide an adequate variety of food in appropriate amounts for both male and female prisoners. Thus the types of meals provided by the national menus would appear to be suitable for prisoners with diabetes.

(h) Early Release on Compassionate Grounds

In a wider sense, "standard of care" refers to the qualities of staff, the facilities they are expected to work in, medical equipment and the policies, procedures and practices that govern their work.

A departmental policy allows seriously ill prisoners to be considered for early release. The New Zealand Parole Board (NZPB) has the power to direct a prisoner's early release on compassionate grounds under section 41(1)(b) of the Parole Act 2002. Releasing a prisoner under this section would usually have little medical benefit. Nevertheless, most prisoners would retain a greater level of dignity by being released, rather than dying in prison.

We comment on early release as, in most cases, it is related to health issues.

There is nothing in the Parole Act or in prison policy that prevents a prisoner (or his/her family) from applying directly to the NZPB for early release under section 41 of the Parole Act 2002.

Applications for release on compassionate grounds are initially completed by Health Services staff. They are forwarded via the prison manager to the Prison Services National Service Manager at National Office, Wellington.

The Department's policy PSOM R.02.04 (Referral and decision of NZPB) states that, upon receipt of report and supporting documentation, Prison Services prepare a formal recommendation to the NZPB supporting or not supporting the early release of the prisoner.

The Department's policy is quite clear. However, we highlight in our report an instance where an application for early release, which was received at the Department's National Office, was not submitted to the NZPB. This was due to uncertainty regarding the possible risk posed by the terminally ill prisoner who at that time was in a rest-home. In the meantime, before additional information regarding the prisoner's level of risk could be compiled and sent to National Office, the prisoner died. The Department's application, therefore, had not been considered by the NZPB.

The Department's view at the time was that there was no legal obligation on its part that requires an application for release on compassionate grounds be forwarded to the NZPB. The Department said:

"When an offender meets the statutory grounds for s41 of the Parole Act, the Department must turn its mind to whether or not an application is made to the Chairman [of the Parole Board]. However, there is no duty in law for an application to be made by the Department. Nor is there any duty on any other person in the circumstances. Section 41 of the Parole Act is an enabling provision for the Department and for the Board."

While the Department's view is that there is no legal obligation on its part to make application to the NZPB, we consider that the Department has a moral responsibility in this respect to ensure that all early release applications are managed with expediency.

The circumstances surrounding the early release application above may have been unique. However, with an aging prison population and the likely increase in early release applications, our view is that all applications pursuant to section 41(1)(b) made by prison staff to the Department's National Office must be forwarded to the NZPB at the first opportunity. This we hope will ensure that the NZPB has ample time to consider whether or not a prisoner should be released subject to section 41 of the Parole Act.

(i) Prisoner Purchases

Following a prisoner's reception at prison, a Trust Account is established by the Department to manage his/her personal finances.

Access is given for prisoners to spend their own money on personal items that are not provided by the prison. Prisoner trust account expenditure is limited to a maximum of \$70.00 per week. Expenditure above this amount and purchases for exception one-off purchases require residential manager approval.

Each prison has a written purchasing procedure that identifies the timetable, purchase and delivery of prisoners' requested goods. A nationally agreed list of items for purchase was established in 2009. The method by which prisoners can purchase a limited array of food and personal items is commonly called the "P119 system".

A prisoner wishing to purchase an item over and above the standardised P119 list is able to do so. A prisoner "Request to Expend Funds" form is completed for purchasing medical, dietary or religious items not included in the canteen list (e.g. additional food, sweets to manage diabetes or the purchase of reading glasses).

For medical or dietary items a unit manager must, before making a decision, consult Health Services staff.

Common over-the-counter diet supplements and medical or quasi-medical products are thus items that prisoners can purchase, but only by special approval (assuming that the prisoner's concern does not amount to a medical condition that requires formal treatment). A typical example would be vitamin and mineral supplements.

The Department, not unreasonably, takes the view that prison diets are fully adequate, and any health problems should be the subject of formal medical treatment. However, the presence of numerous health product stores shows the extent to which significant numbers of persons believe supplements to have health benefits – and we are certainly not in a position to disagree.

Some examples of this are outlined below:

1. A prisoner requested QV lotion which is an item outside the standard canteen list. (QV is a skin lotion primarily concerned with dry skin conditions such as eczema and psoriasis.) The item was initially approved by a unit manager. When the item was finally received at the prison the type of container was of concern to staff, so it was not issued to him.
2. A prisoner at Waikeria Prison had approval to purchase ointment for a sore knee. When he transferred to another prison, his request for the same ointment was refused on the basis that it could distract drug dogs. The prisoner said he was talked into using another ointment, which was less effective in the prisoner's view.
3. A prisoner accustomed to purchasing sports-rub to ease sore muscles in his legs had his request declined, because Health Services staff considered there was no scientific evidence to show that the preparation actually worked.
4. Omega 3, found in fish oil, is generally held to have health benefits. With this in mind, a prisoner obtained approval to purchase tins of salmon and sardines. He had had a heart operation and considered the products to be beneficial. On transferring to another prison, he was denied approval to continue to purchase those items.

We offer no opinion on the decisions outlined above. We refer to the cases only to show the lack of consistency in applying policy within the system.

The Department must ensure that prisoners do not harm themselves by overdosing or misusing purchases for criminal intent. Although the Department maintains that the national menus for prisoners are adequate, and therefore vitamins and minerals are not needed, it seems there is little opportunity for prisoners to be proactive in catering for their own health needs.

Our general view is that, if a prisoner has had approval to purchase an item but is transferred to another unit of similar security regime, he/she should not be denied approval to continue to purchase that item. Any such inconsistency is undesirable, and conflicting decisions are open to challenge on the ground of arbitrariness.

(j) Clinical Governance

As part of prison managers' responsibility for the safe custody and welfare of prisoners, they are responsible for the delivery of healthcare services within the prison.

Clinical governance is about making sure that within an organisation there are proper arrangements in place for managing, monitoring and improving performance of health staff.

We saw little evidence of healthcare quality being addressed at prison management level.

We suggest the establishment of a clinical governance committee chaired by the prison manager, and the identification of a senior clinician to take the lead on clinical governance development at each prison.

In response to the Draft Report, the Department said:

"The Department has a new comprehensive clinical governance framework in place which does include prison managers. However, the leadership remains with Health Services."

Chapter 14 - HEALTH CENTRE OPERATIONS

(a) General Description of Health Centres

Regulation 71 of Corrections Regulations 2005 requires:

"Every prison must have an area set aside as a Health Centre. The Health Centre must be equipped with emergency first-aid facilities, examination rooms and secure facilities to store medical supplies and medicines."

Health Centres provide the central hub of Health Service activities. They usually consist of consultation rooms, storage rooms (health files and medication), offices, a dentist's surgery and staffroom.

Some prisons have modern or refurbished Health Centres. These have the appearance of newly-built community Medical Centres. Others fall below this standard.

Our Investigator visited a Health Centre that had no separate "clean" or "dirty" area. A staff hand basin substituted as a "dirty" area. A "dirty" area is where used instruments are cleaned, while a "clean" area is used to prepare for a medical procedure. The rationale is to reduce cross-contamination.

A Team Leader (Health) told us:

"Inadequate floor space means that the Health Centre is often congested. Clinics have been cancelled due to safety reasons."

We recommend that the Department give consideration to the refurbishment or relocation of older Health Centres.

In its response to the Draft Report, the Department said:

"The Department will establish a process to review health facilities and include (sic) in the Department's capital work plan to ensure adequate facilities are provided."

(b) Inside Prison Health Centres



This Health Centre has no separate “clean” or “dirty” area. The staff hand basin on the right is used as a “dirty” area.



Health Services staff complained about the lack of storage space evident in the photograph. Unused health files are stored in the main administration area of the prison. Non-Health Services staff could have access to those files.



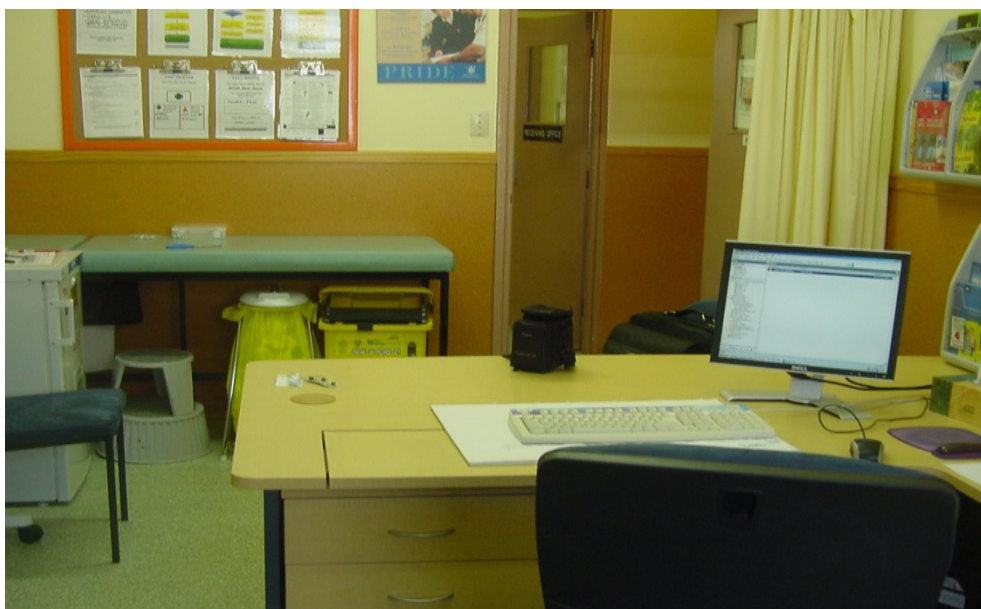
Because of a lack of storage space, nurses have had to utilise this high cupboard.



Because of inadequate floor space this Health Centre is often congested.



The mental health team at this prison no longer use the Health Centre to interview prisoners due to security issues and congestion.



This consultation room is adjacent to the Receiving Office. At times, due to the number of prisoners in the Receiving Office, clinics have been cancelled.



Inside the medication room at a newer Health Centre. The fridges on the left are used to store some types of medication.



Emergency equipment is carried on a trolley for ease of transport. Random checks at two other prisons showed that the required checklist of equipment was not up-to-date.



Prisoners receive methadone through the metal device shown in the photograph.



Some Health Centres have treatment rooms that are not dissimilar to those found in modern General Practice facilities.



Newer Health Centres have specially built showering facilities for prisoners with a high level of physical incapacity.

(c) Custodial “Runners”

Prisoners attending Health Centres to see a nurse, Medical Officer or dentist, are reliant on custodial staff escorting them to and from clinics. Often referred to as “runners”, these custodial staff also provide supervision where necessary.

In most cases, escorting personnel are rostered from the prison’s Custodial Services Unit. Health Services staff instruct “runners” regarding the organisation of escorts. Those staff serve a limited period of time at a Health Centre before being rostered to other duties.

Prisoners waiting for consultations are usually held in one or two holding cells. Certain categories of prisoners cannot be placed together, such as sentenced and remand prisoners. Thus, the number of prisoners who can be present at a Health Centre at any one time can be very limited.

Health Centre staff complained that the reliance on custodial “runners” often impacted on the delivery of health services. Custodial staff shortages and prison movements could often result in a reduction or cancellation of clinics. This could happen with very little notice. As there is often no communication with prisoners regarding delay or cancellation, prisoners as well as Health Centre staff are left feeling frustrated and confused.

A Team Leader (Health) remarked, “*when custody are short staffed, the waitlist is shortened*”. Prisoners who had anticipated seeing a Medical Officer or nurse would therefore have to wait until another time.

At a prison we visited, only one “runner” was on duty. This meant that the officer had to escort a prisoner back to his unit before escorting another prisoner to the Health Centre. In the interim, medical staff simply had to wait. This did not seem to us to be an effective use of Health Centre facilities or the Medical Officer’s time. A nurse told us that at weekends, there are no custodial “runners”. The on-duty nurse must contact unit staff to escort prisoners to the Health Centre. Unit routines and unexpected incidents can cause delay. This is further complicated by unit staff inadvertently bringing the wrong prisoner to the Health Centre, or escorting too many prisoners for the capacity of the holding cells.

Apart from Health Centres, prisoners are also routinely seen by nurses or Medical Officers at unit health clinics. Some units have a medical room where a Medical Officer and/or nurse may undertake the screening and/or treatment of prisoners. Prisoners are called over the unit intercom to attend the clinic at set times during the week. This procedure is reliant on that unit’s on-duty custodial staff to manage and, in the main, clinics are well-organised.

If permanently rostered “runners” were employed this would, in our view, certainly aid Health Centre operations. Greater familiarity with prison routines and Health Centre operations would help eliminate some of the problems associated with the escorting of prisoners to clinics.

In our view, the manifold small problems with regard to escorts drawn to our attention contribute to what is seen as a major impediment to the efficient running of Health Centre clinics.

We recommend that the Department examine whether or not the current provision of “runners” at prisons is sufficient to meet the health needs of prisoners.

In its response to the Draft Report, the Department said:

“The current Health Services work plan identifies the need to develop appropriate guidelines for managing the relationship between Health Services and the wider Prison Service. Consideration of the appropriateness and management of ‘runners’ will be included in this work.”

(d) Procurement of Medical Equipment

Depending on the cost, a Health Centre Manager can utilise Health Services funding to purchase medical equipment, or alternatively approval is sought from the National Health Manager.

At a prison with five separate health units, the Team Leader (Health) complained that each one had antiquated equipment and, in particular, old blood-pressure measuring equipment.

A Medical Officer said he had requested a wall-mounted otoscope - a medical device which is used to look into the ears. Health practitioners use otoscopes to screen for illness during regular check-ups, and also to investigate when a symptom involves the ears. The Medical Officer’s request was declined on the basis that the equipment was too expensive.

The Medical Officer said: “Can’t get equipment, but electrocardiograms...” He suggested that he was unable to obtain basic medical equipment, yet the Department had spent a large sum of money on higher-end equipment.

Lack of medical equipment is not the only problem Health Services staff encounter. A senior nurse at one prison commented on the logistical problems that had arisen due to a lack of printers. Prescriptions, instead of being printed at the Health Centre, were printed in the Principal Corrections Officer’s office. Delays were incurred while the prescriptions were brought to the Medical Officer for signing.

Health/medical equipment is sometimes expensive. However, the cost of purchasing medical equipment cannot be used as justification for failing to provide treatment and care that is required in order to meet the requirements of section 75 of the Corrections Act 2004.

Any inability of Medical Officers to procure modern medical equipment inevitably detracts from their ability to screen effectively for illness or disease.

This is not acceptable.

We recommend that the Department undertake an inventory of Health Services equipment at all sites to identify any shortfalls in the provision of such equipment, and remedy these.

In its response to the Draft Report, the Department said:

“The HS Health Equipment Policy Procedures describe the health equipment which should be available at all sites and includes direction on the purchase of health equipment. The Department will ask all Health Centres to audit against the Equipment Policy and Procedures to ensure the requirement equipment is in place, or is scheduled (if relevant) for purchase through the Capex process.”

(e) Privacy During Medical and other consultations

At General Practice surgeries it is not uncommon to read notices asking patients to move away from the reception area if the receptionist is on the telephone. This is to provide a degree of privacy to the patient who is calling.

Right 1(2) of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights Regulation 1996 states, “every consumer has the right to have his or her privacy respected”.

Rule 5 of the Health Information Privacy Code 1994 states:

- 1) A health agency that holds health information must ensure:
 - a) that the information is protected, by such security safeguards as it is reasonable in the circumstances to take, against:
 - i. loss;
 - ii. access, use, modification, or disclosure, except with the authority of the agency; and
 - iii. other misuse;

- b) *that if it is necessary for the information to be given to a person in connection with the provision of a service to the health agency, including any storing, processing, or destruction of the information, everything reasonably within the power of the health agency is done to prevent unauthorised use or unauthorised disclosure of the information; and*
- c) *where a document containing health information is not to be kept, the document is disposed of in a manner that preserves the privacy of the individual.*

A prisoner expressed his concerns in this way:

"There is no privacy at consultations. Knowledge is out in the compound and is discussed. Everyone knows prisoners' health concerns."

The lack of privacy during consultations was suggested by a prisoner as the reason why prisoners in his unit knew about his medical problems. The transgender prisoner was concerned that, because prisoners knew about his health problems and the type of medication he is required to take, he might be targeted by some.

In the prison environment, the level of privacy afforded to prisoners in Health Centres is sometimes limited. Custodial staff are required to be present to ensure the safety of nursing staff, and to supervise the movement of prisoners in and out of Health Centres. Custodial staff are often close enough to hear what is being discussed during consultations.

We were told that departmental psychology staff complained that prisoner interviews had to be undertaken with the interview room door ajar. We appreciate the need to ensure the safety of staff, but it affords little privacy for the prisoner, when custodial staff and prisoners pass by.

Outside Health Centres, medication is often issued when prisoners, as a group, are called to the unit guardroom. An indication of the type of medicine issued is likely to reveal the nature of the condition – particularly in the case of well-known medication such as anti-depressants.

In the general community many requests for medical advice or assistance come from a third party, usually a close relative or neighbour who can be thought to be calling with the patient's consent. In prison, prisoners have no choice but to use an intermediary to gain urgent care. That intermediary may be a nurse, but is often a prison officer. Consent for healthcare cannot be assumed and special care should be exercised to avoid the disclosure of confidential information.

There can be tension between the requirement to respect prisoners' privacy and dignity, and the need for security. This was evident at a prison our Investigator visited. In some units, a yellow square is marked on the floor beside guardroom entrances. This is where prisoners are expected to stand when receiving medication. The procedure, we believe, deprives the prisoner of any privacy and limits the opportunity to discuss health matters with Health Services staff.

A loss of privacy is an inevitable consequence of imprisonment. However, any procedures and practices that may unnecessarily impede prisoner privacy, such as a yellow square where prisoners stand, should be avoided.

Chapter 15 - HEALTH SCREENING AND ASSESSMENT ON RECEPTION

Every prisoner entering prison has their health needs assessed, including whether or not they are a risk to themselves or others.

A Reception Health Screen is required to be completed by Health Services staff within four hours of a prisoner's reception when a prisoner has been transferred from another prison, on first reception as a remand prisoner, and on first reception as a sentenced prisoner. Following this screening any urgent medical needs are treated, the prisoner's health file is created, and any health needs that the prisoner's unit manager needs to be aware of are advised immediately.

An Initial Health Assessment, also completed by Health Services staff, is then completed within 24 hours. The Initial Health Assessment provides a broader indication of a prisoner's health needs. The assessment records the prisoner's demographic details, past medical and family history, and other relevant physical factors. It is at this time that the prisoner is advised of the health services available to him/her at prison.

The Department has told us that occasionally there are instances when the Initial Health Screens cannot be completed within the required timeframe, as for example, when a receiving prison receives a large influx of prisoners late in the day. Similarly, Initial Health Assessments are sometimes not completed when they should be, in instances where prisoners are attending Court.

Health Services staff at receiving prisons commented that at times they were under particular pressure at reception time. A receiving prison is one that receives remand prisoners. When prisoners transfer between non-receiving prisons, health assessments have, in the main, already been done. Rolleston Prison, for example, is a non-receiving prison by virtue of the fact that accused prisoners are held at Christchurch Men's Prison. If sentenced, prisoners may be transferred to Rolleston Prison at a later time.

A Health Services staff member at a receiving institution said:

"Implications are a lengthier health reception and consent process as opposed to just a reception health screen. All received prisoners must be seen by MO within a week, sorting of health and meds with external providers. Because we are a non-youth prison often they need to be txed (transferred) out and then back again for court appearances which results in more movements and health visits. These prisoners are by nature of age at risk and therefore require visits each day and recording in medtech. All existing acute conditions need sorting before tx (transfer). In essence I would see the hard yards being done at the receiving prison so that end of line prisons get a more stable prisoner."

Prisoners' health needs identified during the Initial Health Assessment are met by a nurse, or the prisoner is referred to the Medical Officer.

Prisoners who have non-urgent or no health needs on reception, are screened by a nurse and placed on the Medical Officer's appointment list to be seen at the next available time.

On 17 June 2010 we were advised by the Department of the results of a Health Assessment pilot. The pilot had been trialled since August 2009. One of the outcomes the pilot hoped to achieve was to use Medical Officers' resources more effectively. The procedure has now been implemented at all prisons.

As a result of the pilot, the assessment procedure has been modified to include:

1. Prisoners (except for transferring prisoners and some prisoners returning from Court) will receive a more comprehensive assessment on arrival;
2. Based on this assessment the prisoner will receive a triage score;
3. The triage score will guide health services as to when a full health assessment must be undertaken. The full health assessment can be completed up to 7 days following arrival depending on clinical indicators;
4. Medical Officers will no longer automatically see every new prisoner. Medical Officers will focus on assessing and providing interventions according to a prisoner's clinical need;
5. All new prisoners will be offered a cardiovascular risk assessment (if clinically required) within eight weeks of arrival. This will also be an opportunity to discuss any lifestyle changes to support improved health outcomes; and
6. Prisoners will also now receive (generally via kiosks) a Health Information Pamphlet outlining how to access health services as well as general information about health.

We note that Medical Officers will not necessarily assess every new prisoner. The Department said:

"One outcome we did want to achieve during the pilot was to use our Medical Officer resources more effectively. The feedback has been that Medical Officers are now able to focus on prisoners who require medical intervention as opposed to seeing all new prisoners regardless of clinical requirements."

A triage score will guide health services as to whether or not a prisoner should be assessed by a Medical Officer. Additional reliance is placed on nurse screening and we emphasise our hope that nurses will receive ongoing and regular training in screening/triage techniques.

Chapter 16 - PRISONERS WITH MENTAL HEALTH PROBLEMS

(a) General Comment

Prisoners with mental health problems present the Department with considerable management difficulties. From our experience in prison matters, we include a number of examples that highlight those difficulties.

Example 1

Staff reported that following a settled period, the prisoner's presentation changed abruptly. Prior to this she had been calm and co-operative. Without any apparent precipitant, she began to refuse food and then began smearing faeces on the floor, wall and on herself. She was unco-operative in cleaning the cell or in showering herself. She spent periods of several hours screaming and wailing and, of note, she spent a number of hours screaming that she wanted her "mum".

Example 2

A nurse was called to attend to a prisoner. He had earlier urinated on the floor and was voicing paranoid thoughts that the prison managers were sexually molesting his daughter and had killed his son. He made two running jumps at the wall and deliberately smacked his forehead with force against the wall. He began frothing from the mouth and then proceeded to shred his stitch gown to tie a noose.

At another time, the same prisoner ran head first into the window of his cell. The nurse on duty at the time recalled the incident in detail. She said:

"I came downstairs and heard a thump. I saw that (name of prisoner omitted) had banged his head. I saw him run headfirst into the glass window in his cell and there was an explosion of blood. I thought his head would be smashed."

Head protectors were not available at the prison at that time so custodial staff had no means of protecting the prisoner's head from injury.

Example 3

A custodial officer advised Health Services staff that a prisoner had re-opened his left arm wound and had cut his right arm. He told Health Services staff that he had done it with a staple and liked the sight of blood. The prisoner refused any dressing but did wash his arms under a tap.

At another time, the same prisoner sliced his wrists with a piece of metal. The laceration to the right wrist was deep and he was escorted to hospital to ensure no nerve damage had resulted. For this prisoner, episodes of self-harm are more prevalent at the anniversary date of his brother's death.

Example 4

The prisoner reported that he swallowed three pieces of metal that he obtained from under the door leading to the access alley in the Special Needs Unit. He saw the prison doctor, who arranged for him to have an x-ray the next day. He told the prison doctor that he did this because he was angry with his family.

At a later date, the prisoner reported that he swallowed three razor blades from an electric shaver. He was seen by the prison doctor, and subsequently taken to the Auckland Central Hospital.

Prison records show that the prisoner subsequently swallowed a nail clipper, bleach, a piece of lino, a metal ID tag, the end of a toothbrush and a piece of wire.

Example 5

The following examples are all associated with the same prisoner:

- i. Custodial staff heard a loud bang followed by loud music coming from the prisoner's cell. Staff opened the observation slide and saw that the prisoner had cut her legs with glass from her broken television set;
- ii. Unit staff observed smoke and water coming from under the door of the prisoner's cell. The fire alarm system had been deliberately activated. Due to the amount of smoke, all prisoners in the unit were relocated to the gym;
- iii. Staff were called to attend the At Risk Unit. The prisoner had wrapped a piece of cloth around her neck;
- iv. On their arrival at the prisoner's cell, staff observed burnt hair on the floor of the cell. The prisoner was crying hysterically and relocated to the At Risk Unit;
- v. Unit staff noticed blood around the prisoner's toilet area. The prisoner told staff that she had cut her vaginal area with a broken plastic knife; and
- vi. The prisoner commenced screaming and yelling. She said to staff that she was going to strangle herself. The prisoner was duly removed to the At Risk Unit.

The Ministry of Health and Department of Corrections have responsibilities for meeting the needs of prisoners with mental health problems.

"Mental illness" or "mental disorder" are terms not easily defined. "Building on Strengths" (Ministry of Health, 2002) describes mental illness as:

"Any clinically significant behavioural or psychological syndrome characterised by the presence of distressing symptoms or significant impairment of functioning."

The causes of mental illness are also not easily determined. In "Return to Work" (Mental Health Commission 2007) the following comment is made:

"The exact causes of mental illness are unclear – although it is thought that there may be a number of influences, including psychosocial, stress-related, biochemical, and genetic factors. Many things may also contribute to the onset of mental illness such as trauma, conflict, alcohol or drug use, unresolving and increasing stressors and demands."

Many people sentenced to prison have complex mental health needs, often linked to substance abuse, and ranging from acute psychosis, through to personality disorders and high levels of anxiety and depression.

The delivery of mental health services for prisoners is made more difficult by the constraints of a prison environment. As the Auditor-General pointed out in his 2008 report *"Mental Health Services for Prisoners"*:

"It can be difficult to administer medication outside the usual prison routines, and there can be delays in getting prisoners to clinics because there are not enough officers available for escort duties. Prisoners whose condition is such that they are subject to compulsory treatment orders must be transferred to hospital which puts additional pressure on forensic in-patient services."

The delivery of mental healthcare is further complicated by the transfer of prisoners. Prisoners can be moved between prisons to manage prison muster levels, or to attend court hearings at another town. This can be disruptive of an appropriate continuity of care.

In 1999 the first detailed study of mental illness amongst New Zealand prisoners, the *"National Survey of Psychiatric Morbidity in New Zealand Prisons"*, was published. When compared to the general community, prisoners have significantly higher levels of psychiatric conditions. The study found that, when compared to the community sample (as presented in the Christchurch Epidemiological study of Wells et al (1989), and Oakley-Browne et al (1989)), a number of conditions were significantly elevated. These were:

- major depressive disorder;
- bipolar disorder, especially current episode of mania;
- schizophrenia and related conditions;
- substance abuse and dependence, especially in women;
- post traumatic stress disorder;
- obsessive compulsive disorder; and
- personality disorder.

The Ministry of Health report *"Services for People with Mental Illness in the Justice System"* 2001 estimated that prisoners were three times more likely to require access to specialist mental health services than people in the general population. The Ministry estimates that 10% of the prison population could experience a mental illness requiring specialist care. Almost a third of the prison population could experience mild to moderate mental health problems.

Dr Sandy Simpson, Honorary Clinical Associate Professor and Clinical Director at the Mason Clinic (now Clinical Director of the Law and Health Program at the Centre for Addiction and Mental Health, Toronto, Canada), said in an article published in *"Rethinking Crime and Punishment"*, Newsletter No 35, April 2008:

"In a major study of mental illness in New Zealand prisons, we found that the most serious mental illnesses (psychotic illness, bipolar mood disorder and major depression) were over represented in prison. We estimated that about 15% of all inmates should be receiving mental healthcare for one of these problems, as they would in the community. Lifetime substance misuse problems were present in over 80% of inmates."

The Mental Health (Compulsory Assessment and Treatment) Act 1992 defines mental disorder, in relation to any person as:

"An abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it -

- (a) Poses a serious danger to the health or safety of that person or of others; or*
- (b) Seriously diminishes the capacity of that person to take care of himself or herself"*

Our understanding is that the type of mental disorders that usually require the assessment and treatment of prisoners at a Regional Forensic Psychiatry Services facility are those categorised in the Diagnostic and Statistical Manual of Mental Disorders 4 under Axis 1, namely schizophrenia, depression, bi-polar, psychosis and mood disorders.

We do not purport to have expertise in the field of mental illness. However, prisoners who demonstrate highly disruptive and disturbed behaviour that a lay person would most likely describe as *"mad"*, does not necessarily mean they have a *"mental illness"*, as it is defined.

Our general investigation of Health Services would suggest that there are deficiencies regarding the care of mentally unwell prisoners. We appreciate that funding for health services in general, and mental health services in particular, is a question that arises. However, we regard the current situation whereby custodial staff have to manage prisoners who, by any lay person's measure, are grossly disturbed is unsatisfactory for both prisoners and staff. In this regard, we note that there is a distinction to be made between *"treatment"* which suggests intervention that may lead to improvement in the particular conditions, and *"care"* which may amount to no more than physical containment.

Sadly, prisons seem to be viewed as the best place for *"care"* in the sense of physical containment.

(b) The Department's Responsibilities

The Department is responsible for providing primary healthcare, including primary mental health services, to all prisoners. In accordance with section 75(2) of the Corrections Act 2004 healthcare provided to prisoners must be reasonably equivalent to the standard of care available to the public. This includes mental healthcare. Primary mental healthcare means health services delivered by Medical Officers, nursing staff and others who refer prisoners to mental health services.

Psychiatric morbidity, or the rate of mental illness or proportion of mentally ill persons in a given locality, as we have discussed earlier, is prevalent amongst prisoners. Most of those in prison with mental health problems, including the majority of those with complex treatment needs, are managed in prison primary care. Significant unmet needs in prison are reported in terms of common mental health problems including depression, anxiety, emotional distress and adjustment problems.

We found primary mental healthcare in prisons variable. Many Medical Officers have limited training in psychiatry, and prison nurses who provide a significant amount of the primary care service are not supported from a clinical perspective in dealing with these, often difficult, cases. From our interviews, relationships with forensic teams were good, but Medical Officers describe a shortage of counselling and therapeutic interventions for primary mental health and substance misuse problems.

Some prison healthcare teams had no mental health nurses to provide specialised care to those who fell beneath the threshold of severe and enduring illness. Prison nurses are a mix of those qualified in general nursing and in mental health nursing. On the whole, they do not have specialist roles and are expected to provide a range of services.

In general, we found that services were insufficiently responsive to the diverse needs of prisoners with mental health problems.

(c) The Ministry of Health's Responsibilities

The Ministry of Health sets the strategic direction for Health and Disability Services, and is responsible for planning and funding Forensic Mental Health Services. As the funder of Forensic Mental Health Services, the Ministry sets agreements with DHBs covering services and responsibilities under legislation and monitors the extent to which DHBs comply with mental health sector standards.

DHBs organise forensic mental health services regionally, which they deliver through six Regional Forensic Psychiatry Services (RFPS). Five District Health Boards act as hosts for the Regional Forensic Psychiatry Mental Health Services. They are the Otago DHB, Waitemata DHB, Waikato DHB, Capital and Coast DHB and the Canterbury DHB.

The RFPS provide the Department with specialised services including outpatient clinics within the prison environment and, when necessary, the transfer of mentally ill prisoners into medium secure hospital facilities pursuant to sections 45 and 46 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

RFPS for prisoners use multidisciplinary teams to provide forensic mental health services to mentally ill offenders and those who pose a high risk of offending. The aim of the forensic mental health service is to provide effective assessment, treatment and rehabilitation for:

- people charged with criminal offences who have, or may have a mental illness;
- offenders with a mental illness; and
- people whose potential danger to themselves and others is such that community mental health services cannot manage them.

Section 45 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 enables a prison manager to make an application to have a prisoner assessed, if the prison manager has reasonable grounds to believe that the prisoner may be mentally disordered.

The transfer and assessment of the prisoner at a Regional Forensic Psychiatry facility then takes place. If need be, the prisoner is made subject to a Compulsory Inpatient Treatment Order and compelled to accept treatment against his/her wishes. This may include medication.

If the prisoner's responsible clinician is of the view that the prisoner's mental illness is ameliorated to a safe state and he/she can be safely maintained and managed in prison, a formal request is made to the Director of Mental Health.

Should the prisoner be transferred back to prison, the Compulsory Inpatient Treatment Order ends and there is no further compulsion for the prisoner to take medication.

Forensic teams in prison help people who would, in the community, qualify for help from specialist mental health services because they have severe and enduring problems. Yet, in practice, forensic teams deal with many prisoners with treatable primary level mental health problems because of a lack of alternative services and a lack of clarity about the role of secondary mental healthcare in prisons.

The result is that forensic team resources are diluted, and the teams are treated as the sole resource for all those with mental health problems, rather than as specialist teams for those with more complex and severe conditions.

(d) The Mental Health Screening Tool

The Department's policy is that every prisoner must be assessed promptly after arriving at prison to identify any immediate physical or mental health, safety, or security needs. It must address any needs identified by that assessment.

Prisoners undergo a Reception Health Screen within four hours of reception. This is a brief screen to identify any immediate health needs that are to be addressed. Included in this are questions about the prisoner's current medication, medication they have with them and observations of mental state are noted and recorded.

The Department has told us: *"severe, and to a degree, moderate mental illness would be identified at this point."*

Within 24 hours, a more in-depth health assessment is undertaken. This has a section which focuses on mental health and asks:

1. Have you ever received psychiatric/psychological treatment or counselling? Yes / No

What did it consist of and where did it occur?

2. Have you ever taken medication for a mental or emotional condition? Yes / No

What was it?

3. Have you ever considered or attempted suicide? Yes / No

If so, do you know why?

Nurses completing the health assessment are required to note their observations of mental state.

The Auditor-General's report in relation to the *"Mental Health of Prisoners"* 2008, recommended that the Department of Corrections *"improve the information available for identifying trends in prisoners' mental health needs and for planning services by establishing a system to collect and record prisoners' mental health information as part of the implementation of the proposed mental health screening tool"*.

We supported the Auditor-General's recommendations. In the Ombudsmen's Annual Report 2007-2008 we stated:

"The Controller and Auditor-General published a report in March 2008 on Mental Health Services for Prisoners, which made a number of recommendations for improvements to mental health services to prisoners through liaison between the Ministry of Health and the Department of Corrections. We would strongly encourage such efforts."

Our view was that special attention must be paid to the identification of mental health needs at the time of a prisoner's reception. Identifying prisoners' mental health needs when they first enter an institution is critical to providing necessary services and enhancing safety in a prison setting.

A psychiatrist employed with the Canterbury Health Board told us: *"A Mental Health Screening Tool is important. It is easy to use. If implemented, it will improve treatment and provide early recognition of mental illness."*

When we commenced our investigation of the Department's provision of Health Services for prisoners, a Mental Health Screening Tool (MHST) had been developed and validated for use in New Zealand prisons. However, it had not been implemented due to a lack of funding.

To implement the MHST in prisons, the Department said additional funding would be required for:

- An additional 20.76 full-time equivalent nursing positions;
- National nurse recruitment campaign to increase nurse workforce;

- Additional pharmaceutical costs which are likely to rise as a consequence of identifying increased mental health needs; and
- Custodial staff for escorting and supervision of prisoners.

In September 2010, we were advised by the Department's National Health Manager that funding for the implementation of the MHST had been made available. We were advised that the Department is on track to implement the tool in the 2011-2012 financial year. So far the Department has developed the project plan, appointed a project manager, worked with the Steering Committee on scope issues and determined the likely number of prisoners who will go through each stage (screen, referral for assessment, refer back for treatment). It has also determined the best approach to "packages of care" (where mild to moderate mental illnesses will be dealt with by prison health services), and engaged with Regional Forensic Services on the referral and assessment process. The Department is currently developing "packages of care" with Regional Forensic Services with a view that the tender process will be completed by February or March 2012 year. A progressive roll out of the tool leading up to full implementation should be completed by June 2012.

The mental health screening of prisoners would only apply to male prisoners. However, research related to the development of a screening tool for youth and female prisoners is considered a priority by the Department.

In a report titled *"Project Brief MHST Implementation"*, the Department said:

"As a targeted intervention that assesses male prisoners on reception, the Mental Health Screening Tool (MHST) provides the opportunity to more effectively identify mental health issues which then enables the provision of appropriate treatment interventions. This assists in reducing the severity and negative long term impact of mental illness. The result of this within prisons is better engagement in programmes and a reduction in disruptive behaviour. Longer term it contributes to successful community re-integration."

The Department said that the expected benefits for prisoners with mental health needs are that they will have access to appropriate treatment interventions resulting in reduced severity of mental illness, and improved participation in rehabilitative programmes.

We welcome the implementation of the MHST. Prisoners identified as having mild-moderate mental health problems should have improved access to appropriate interventions designed to meet their specific needs.

(e) Prisoners At Risk of Self-harm

Guidelines regarding the Department's management of prisoners at risk to themselves are found in Policy and Procedure B.14.

The Policy Standard is:

"Every effort is to be made to identify prisoners at-risk, and manage them to minimise their risk of self-harm."

(i) Assessment of at risk prisoners

On reception, prisoners are assessed and their at-risk status identified using a Reception Risk Assessment. The reception risk assessment must be undertaken following a prisoner's initial reception into custody, or reception upon returning to custody from bail or parole. The assessment must be completed within four hours of the prisoner's reception.

The Department said that prisoners are more likely to have mental disorders and illnesses than the general population, and are therefore more likely to be at-risk of suicide. The Department said: *"Suicide attempts are an unfortunate reality in prisons around the world"*. To target specific times or circumstances that could cause a prisoner's level of risk of self-harm to rise, an assessment tool called the Review At Risk Criteria is used.

The prisoner's at risk status must be reviewed when:

- a prisoner returns from Court;
- further charges are laid;
- the custodial status changes;
- upon reception following an inter-prison transfer;
- increase in security classification;
- use of directed segregation;
- use of force;
- a section 107 application is made;
- parole has been deferred for two or more years;
- change in family circumstance e.g. death of a family member, break up of a relationship, losing custody of a child, family group conference; or
- confirmation of serious or terminal illness.

Consideration must be given to reviewing the prisoner's at risk status if:

- an event or incident has the likelihood of a negative impact upon the prisoner;
- the prisoner begins to display negative signs or change in mood or behaviour; or
- knowledge of the prisoner causes concern.

The review risk assessment must be completed within four hours of staff being advised of any of the above events occurring.

When a Review Risk Assessment is initiated, analysis of pre-populated information and a prisoner's response to a series of questions will determine whether or not that prisoner should be placed on at-risk status.

If health and custody staff agree that the prisoner is at risk. The prisoner is to be:

- (i) placed on observations not exceeding 15 minutes (and managed as per PSOM M.05.03 (Observing and managing prisoners at risk))
- (ii) moved to an At Risk Unit. If an at-risk prisoner is also subject to a segregation direction for the purpose of medical oversight, he/she will also need to be managed as per the requirements of segregation under section 60 (1) of the Corrections Act 2004.

If health staff and the assessor agree that there are no apparent risks identified, the prisoner can return to his/her normal routine. If health staff and the assessor cannot agree on the at-risk status of the prisoner, the assessment must then be referred to PCO, residential unit manager or on-call PCO. Pending the decision, the prisoner is to be managed as at risk.

The Review Risk Assessment has limitations. For example, the risk assessment relies heavily on prisoners disclosing relevant information to assessing staff, but we feel that a prisoner with suicidal ideation is unlikely to discuss this at a first-time meeting with a Corrections Officer.

Furthermore, staff are often under pressure, especially when prisoners return from Court. We were told that reviews are sometimes completed in a conveyor belt fashion.

The advantage of the Review Risk Assessment system is that it does provide custodial staff with a relatively easy and formalised method of identifying whether or not prisoners may be at risk of self-harm.

(ii) The management of at risk prisoners

If the prisoner is deemed at risk, a residential unit manager completes a management plan for the prisoner, including an observation regime. If not deemed at risk, the prisoner is returned to the normal induction process.

Prisoners deemed to be at risk are placed in specifically designed At Risk Units. Each cell in an At Risk Unit typically has a smooth concrete ledge used for a bed, with a plastic-covered mattress on it. There is a stainless steel toilet, and an in-built light and security camera. A solid, barrel-shaped stool is bolted to the floor. At Risk Units also contain "round-rooms" which are designed to provide a segregated environment for the management of violent or very disorientated prisoners. Round rooms usually contain little, except a mattress and bedpan. The spartan nature of these cells is designed to minimise the risk of self-harm and injury to other prisoners and staff. Placement in a "round room" requires the maximum observation of prisoners to ensure their safety.

Once a management plan has been developed for an at-risk prisoner, he/she is observed by way of physical sightings according to the individual management plan for that prisoner. The observation interval specified in the plan may be shortened or lengthened if staff dealing with the prisoner consider it warranted. To lengthen the period of time between observations requires the unit manager's written authority.

At Risk Units are intended to ensure prisoners who are at risk of self-harm are protected from doing so. At Risk Units are not psychiatric units, but they serve a definite purpose in that they provide safe observation, oversight and containment. However, the tendency to manage prisoners' risk by restricting access to amenities and by isolating them, although necessary in the short term, is something we fear could contribute to a deterioration of mental state and behaviour in the longer term.

(f) Prisoners with Severe Personality Disorder

The American Psychiatric Association, 1994, defined Personality Disorder as:

"A pervasive pattern of instability of personal relationships, self image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, such as identity disturbance: markedly and persistently unstable self-image or sense of self, impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse), recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior and inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)."

Personality disorders are very prevalent in the prisoner population. The Department's own figures suggest that up to 60% of prisoners meet the criteria for personality disorders.

Personality disorder is characterised by behavioural patterns, such as irrational suspicions, lack of interest in social relationships and pervasive disregard for the law and rights of others. In particular, individuals suffering from "severe personality disorder" are associated with dangerous and violent behaviour. The majority of prisoners with personality disorder cause, at most, some distress to themselves or to their family or friends – for example by their obsessive or compulsive behaviour. But at the other end of the spectrum is a smaller group of prisoners who are very seriously disordered and who pose a very high risk to the public, departmental staff and themselves.

Prisoners with mental health problems, who meet the criteria of the Mental Health (Compulsory Assessment and Treatment) Act 1992, can be transferred to a Regional Forensic Psychiatry Service facility. Assessment and treatment of prisoners at a Forensic Psychiatry Service facility is, as discussed previously, provided to those prisoners affected by an illness categorised in the Diagnostic and Statistical Manual of Mental Disorders 4 under Axis 1. Facilities do not, as a rule, treat and maintain prisoners with purely personality disorders, unless extreme.

Prisoners with personality disorder cannot be admitted to a community mental health unit, such as Te Whetu Tawera (Acute Mental Health Inpatient Unit, Auckland Central) because the facility is not classified as secure and is not mandated or contracted for the specific purpose of holding prisoners.

Thus, those prisoners not deemed mentally ill enough to be admitted to a secure mental health facility as defined by the Mental Health (Compulsory Assessment and Treatment) Act, are managed in a custodial environment. Their condition is monitored by Health Services and Forensic Psychiatry Liaison Teams. Certain types of medication for these prisoners can be prescribed by the prison's Medical Officer although it is the prisoner's choice whether or not he or she accepts such treatment.

Prisoners with personality disorder are often referred to as having behavioural problems. That is, their behaviour is a reaction to, and a way to cope with their immediate environment. They often self-harm to get attention and thereby to have their perceived needs met. Prisoners' bizarre and disruptive behaviour may be seen by custodial staff as a discipline and control problem rather than a medical issue.

Ombudsman Mel Smith's *"Investigation into issues involving the Criminal Justice Sector"* said of this succinctly: *"There is lack of clarity as to at what point people in the mad/bad continuum are cared for in hospital or controlled in prison."*

We are full of praise for custodial staff in their efforts to attend to the needs of personality disordered prisoners. However, they face almost insuperable difficulties in coping with extreme presentations, when they are not specially trained to do so and are doing so in a sub-optimal environment. Even Health Services staff are not mental health specialists. Despite the efforts of staff, the management of prisoners with personality disorder appears to be ad hoc. Prisoners will often drift in and out of At Risk Units, whether they are at risk of self-harm or not.

A psychiatrist told our Investigator that: *"The best people to deal with prisoners with severe personality disorders are people well-trained."* We agree with this sentiment.

If the needs of prisoners with personality disorder, especially those with severe personality disorder, are to be effectively met, a range of therapeutic treatments tailored to each patient's individual needs must be available. The range should include assessment, specialist care and rehabilitation.

A higher level of training for custodial staff in how to manage prisoners with severe personality disorder and the establishment of special units for such prisoners may be something for the Department to consider. However, our view is that a much wider examination of the care and treatment of prisoners with mental illness is required. Only then will real progress be made to address the needs of this particularly vulnerable group.

The Controller and Auditor-General's 2008 report on Mental Health Services for Prisoners made a number of recommendations for improvements to mental health services to prisoners through liaison between the Ministry of Health and the Department of Corrections.

In relation to the Department of Corrections and the Ministry of Health, the recommendations were to:

- *outline the roles and responsibilities for managing prisoners with personality disorders in their Memorandum of Understanding for health services, once they have established those roles and responsibilities; and*
- *share current data on prison musters and service demand to meet their joint needs in planning prisoners' mental health services.*

We would strongly endorse the Controller and Auditor-General's recommendations.

(g) Psychological Services

The Department's Psychological Services is part of Reintegration and Rehabilitation Services and has around 102 psychologists who provide specialist clinical treatment and assessment advice for prisoners. It also supports the Department's initiatives to reduce re-offending by assisting with the design, implementation, and monitoring of rehabilitation programmes.

Only one prison, Mt Eden Corrections Facility, has the services of a psychologist onsite. The part-time position was originally established when the Auckland Central Remand Prison was run privately. After the Government resumed running the prison in 2005, the role of psychologist was not disestablished. The Mt Eden Corrections Facility is now managed by a private company (Serco) and the part-time psychologist position has been retained.

Prison Services can request a psychological report following the prisoner's initial screening, and during sentence planning. Psychological reports are also provided to the Parole Board when the release of a prisoner is to be considered.

The primary function of Psychological Services is the preparation of psychological reports. In the 2007/08 financial year Psychological Services prepared more than 3,000 reports for Prison Services, the New Zealand Parole Board, and the courts.

The National Health Committee's *"Review of Research on the effects of imprisonment on the health of prisoners and their Families"* 2007 said:

"Incarceration brings about ill health. It removes persons from family and society, and dislocates social relationships which otherwise give us a sense of place and well-being. There is a loss of control and autonomy."

Psychological Services does not provide general counselling, grief counselling, AOD counselling, or counselling pertaining to a health need such as adjusting to HIV status. Prisoners can only obtain these services through publicly-funded counselling services, but those are largely restricted to ACC sensitive claims counselling. Prisoners may obtain private counselling but few would be able to afford this.

We understand that in some prison regions there are too few psychologists for the amount of work required of them. The delay in seeing a psychologist as recommended by the Parole Board is not infrequently the subject of complaints to us. We suggest that the Department review the current provision of psychological services for prisoners. The contracting of recognised general counselling services for prisoners may be something to consider.

The bottom line however, in our view, is that prisoners displaying any of the symptoms or behaviours discussed should be treated in a therapeutic environment, not a custodial environment.

Chapter 17 - NON-SMOKING POLICY

Section 6A of the Smoke-free Environments Act 1990 allows prisoners to smoke in their cells. It states:

“The superintendent of a prison must ensure that there is a written policy on smoking in the prison’s cells, prepared for the protection of the health of employees and inmates.

The policy –

- a) must be based on the principles that –*
 - i. as far as is reasonably practicable, an employee or inmate who does not smoke, or does not wish to smoke in the prison, must be protected from smoke arising from smoking in the prison’s cells:*
 - ii. unless it is not reasonably practicable to do otherwise, an inmate who does not wish to smoke in his or her cell must not be required to share it with an inmate who does wish to smoke in it; and*
- b) must state the procedure for making complaints under this Part.”*

There is legislative provision that enables prisoners to smoke in their cells and other designated areas. However, on 28 June 2010, the Minister of Corrections announced that prisons would become completely smoke-free. This policy was implemented with effect from 1 July 2011. From a general health perspective, the policy would appear to be a positive initiative.

In the Ombudsmen’s Annual Report (for the year ended 30 June 2010) we commented, inter alia, that while Corrections staff will only be permitted to smoke in areas outside of unit / prison fences, this might impact on prisoners by leading to further reductions in unlock hours. The Department has advised that our concerns will be monitored and addressed as the policy is implemented, and pragmatic solutions will be found for each site to protect prisoner and staff safety and prisoner entitlements.

Chapter 18 - PROVISION OF PROSTHESES FOR PRISONERS

A prosthesis is a device designed and applied to improve the function of a body part. For the purpose of our investigation we have considered prostheses to include items described in the Department's Prosthesis Support policy, namely, hearing aids, spectacles and dentures.

The purpose of the Department's policy regarding prostheses is to ensure there is a nationally consistent approach. In practice, the policy is most frequently relevant to the provision of appropriate financial support to prisoners for the purchase of hearing aids, spectacles and dentures.

Section 76 of the Social Security Act 1964, provides that benefits are not generally payable to prisoners.

The effect is that prisoners are not entitled to benefits that would enable them to buy prostheses. In the circumstances, the Department does provide some assistance for prisoners to pay for prostheses. Prisoners, via the Department's *"Incentive Allowance Scheme"*, have the ability to work for earnings, either in an outside work gang or in unit-based work. The highest rate of payment is \$0.60 per hour. To achieve this level of payment prisoners must demonstrate exemplary work performance, work skill and behaviour. Prisoners who are unemployed receive earnings of \$2.70 per week.

At its discretion, depending on an assessment of need, the Department will purchase a prosthesis (up to \$1000) and the prisoner is required to repay a percentage of the costs. *"Need"* relates to the degree of loss of hearing or eyesight. For example, age-related deterioration may only require *"over-the-counter"* reading glasses, as opposed to prescription lenses.

Nevertheless, practices as to the Department's contribution vary between prisons. For example, a prisoner at one prison said he had agreed that \$2.00 per week would be taken from his Trust Account for dental work totalling \$1100. Although over the \$1000 limit, he said he had been sentenced to 11 years and would be *"around for a while"*. He complained that the dentist had advised him that two-thirds of the amount of the dental work would have to be paid up front. For this particular prisoner, paying off \$2.00 per week until two-thirds of the amount is paid would take approximately 7 years. It is patently unreasonable to expect a prisoner to wait 7 years before dental work will commence, assuming that the dental work is reasonably required. A two-thirds deposit was the practice at this prison.

At another prison, dental work outside the minimum requirements is done as soon as the prisoner has committed to having money deducted from his trust account. Health Services staff pointed out that the difficulty with this approach is that should a prisoner be unexpectedly released Health Services would be encumbered with a significant debt.

At a further prison, prisoners are expected to contribute half the total cost of the work before prosthetic work will commence. We consider that differences in practice should not exist.

We recommend that the Department develop a nationally-consistent policy regarding the level of prisoner funding required before prostheses are purchased or prosthetic work is undertaken.

In its response to the Draft Report, the Department said:

"The purpose of the Prosthesis Support – Financial Management Policy is to ensure that there is a nationally consistent approach in the provision of appropriate financial support to prisoners with the purchase of dentures, hearing aids and spectacles. The current Health Services work plan includes review of the prosthesis policy, and this will be completed in 2011."

Chapter 19 - THE HEALTH NEEDS OF CERTAIN TYPES OF PRISONERS

(a) Transgender Prisoners

Transgender is an umbrella term used to describe people whose gender identity (sense of themselves as male or female) or gender expression differs from that usually associated with their birth sex. Broadly speaking, anyone whose identity, appearance, or behaviour falls outside of conventional gender norms can be described as transgender. However, we understand that not everyone whose appearance or behaviour is gender-atypical will identify as a transgender person.

The Department does not keep records regarding the number of transgender prisoners in New Zealand prisons.

Transgender and transsexual prisoners (prisoners who have changed, or are in the process of changing their physical sex to conform to their gender identity) have the same health concerns as any other person. However, there are some transgender health needs that are unique. Issues include transitioning (physically altering one's gender appearance to match one's gender identity) and the use of hormone therapy which allows transgender people to begin to develop the physical characteristics of the opposite sex.

The Department's National Policy regarding transgender prisoners (Policy and Procedure Manual D.07 Transgender Prisoners) states that:

"Prisoners who believe that their anatomical or biological gender is opposite to their birth gender are contained in an environment that acknowledges and accepts their gender identification and does not disadvantage or restrict their opportunities for successful reintegration into the community."

Regulation 190 of the Corrections Regulations 2005, requires that:

"Where the chief executive is satisfied that a transgender prisoner has completed gender reassignment surgery, the prisoner must be promptly placed in accommodation that accords with that prisoner's new gender."

The Department considers that, unless a transgender prisoner has completed gender reassignment surgery (or realignment surgery as it is sometimes called), the prisoner, if born male, must be placed in a male prison. Similarly, if a prisoner is born female but considers herself male, she must be placed in a female prison. This is regardless of how long they may have lived as a member of the other gender and medical treatment they may have undergone. Gender reassignment surgery completes gender transition and deals in reshaping key areas of the body.

The Department will not fund sexual reassignment surgery, nor is it considered during a term of imprisonment. Therefore, most prisoners have to be content with hormone treatment.

Transgender prisoners are particularly vulnerable to abuse and/or sexual assault, in part because of the general policy of housing them according to their birth gender, regardless of their current appearance or gender identity. A Health Centre Manager said, *"abuse (of transgender prisoners) goes unrecorded in male prisons"*. A transgender prisoner said this was due to fear of retaliation. Prisoners can place themselves on voluntary segregation away from mainstream prisoners. This may mean reduced access to prison activities and programmes.

Transgender prisoners can continue to receive hormone treatment in prison. However, issues regarding payment for hormone treatment were raised with us. A transgender prisoner at Rimutaka Prison said that after he saw the prison's Medical Officer and an endocrinologist, it was decided that he would pay \$3.00 for 3 months' supply of treatment. This is what he had paid using a Community Card before entering prison.

When he was transferred to another prison he was advised that he would have to pay \$37.00 for 3 months supply. The prisoner was initially unable to pay this amount of money.

In our discussion with this prisoner, he said being transgender in prison is very difficult. He said custodial staff were often insensitive towards transgender prisoners. On one occasion when he approached a unit guardroom, he claimed that custodial staff remarked: *"Oh for goodness sake, what have we here."* Furthermore, he said about 35 out of 60 prisoners in the unit wanted sexual contact. As a transgender prisoner in a male prison, he was subject to routine body searches by male officers.

Regulation 65 of the Corrections Regulations 2005 states that:

"If male and female prisoners are detained in the same prison, they must be detained in separate quarters that are secured by different locking systems."

We accept the need for male and female prisoners to be kept separate. However, transgender prisoners give rise to a difference in what we traditionally understand "male" and "female" to be. The decision as to when a male prisoner is emotionally and physically "female" would involve consideration of expert medical opinion, which as Ombudsmen we are not able to assess. However, it is unreasonable, in our view, for prisoners who are well advanced through gender transition to be detained in a male prison.

As there has been no specific occasion of which we are aware of female to male gender reassignment surgery, we have only considered male to female transgender prisoners in the following recommendation.

We recommend that the Department review its policy regarding the placement of transgender prisoners. For transgender prisoners who have not completed full sexual reassignment, consideration should be given to their placement in a women's prison, if it is their wish to do so.

In its response to the Draft Report, the Department said:

"The Department has a comprehensive transgender prisoner policy (PSOM M.03.05), and will continue to make decisions on the care of transgender prisoners on a case by case basis, based on medical advice."

Further inquiries were made of the Department regarding the management of transgender prisoners.

The Department said it does not intend to review its current policy regarding the placement of transgender prisoners, which reflects the Corrections Regulations 2005. The Department said it expects all prisoners to be treated with decency and believes that the existing policy supports this.

We accept that transgender prisoners must be treated with dignity, as should all prisoners. However, the Department's policy is that transgender prisoners will be placed in accommodation that accords with that prisoner's new gender only when the Chief Executive is satisfied that that the prisoner has completed gender reassignment surgery. Sexual reassignment surgery is not considered by the Department during a term of imprisonment so there is no opportunity for prisoners to be placed in an environment where *"their anatomical or biological gender is opposite to their birth gender"*.

We believe the Department's current policy does not adequately reflect the expectation that transgender prisoners are treated with dignity, nor that it accepts or acknowledges prisoners' gender identification.

(b) Aged and Frail Prisoners

The prison population is aging. In the 1987 New Zealand Prison Census, 29% of prisoners were aged 30 or over, compared with 45% in 1995. This has resulted from the greater number of historic offences being prosecuted, and longer sentences being served for serious violent offences. Prisoners are serving a greater proportion of their sentences in custody.

Preventive detention, effectively a life sentence, was modified under the Sentencing Act 2002 to include a wider range of qualifying sexual and violent offending, such as conspiracy to murder, aggravated robbery, and kidnapping.

Under the Sentencing Act, preventive detention is no longer reserved for those having a record of previous serious violent or sexual offending, and is no longer limited to adults 21 years and over. Preventive detention is now imposed on offenders who are 18 years or over. Courts must impose a minimum period of imprisonment of at least five years.

In most developed world countries, the chronological age of 65 tends to attract the definition of "elderly" or "older" person, possibly because that is the age at which State pensions are commonly paid. Conversely, *"old age"* is seen to begin when active contribution to society has significantly diminished. This is not associated with any particular chronological age.

Ageing inevitably results in the progressive impairment of senses and physical ability, and increases in certain diseases and infirmities.

Section 8 of the New Zealand Public Health and Disability Act 2000 requires that the Minister of Health must determine a strategy for health services, called the New Zealand Health Strategy, to provide the framework for the Government's overall direction of the health sector in improving the health of people and communities. These include to *"improve health and disability outcomes for all New Zealanders, to reduce disparities by improving the health of Maori and other population groups, to provide a community voice in personal health, public health, and disability support services and to facilitate access to, and the dissemination of information for, the delivery of health and disability services in New Zealand."*

The Act established the structure underlying public sector funding and the organisation of health and disability services. It established DHBs, and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations.

The New Zealand health and disability system's statutory framework is made up of over 20 pieces of legislation. The most significant are:

- New Zealand Public Health and Disability Act 2000;
- Health Act 1956; and
- Crown Entities Act 2004.

Government funding of Health and Disability Services means that eligible people may receive free inpatient and outpatient public hospital services, and a range of support services. DHBs are responsible for providing, or funding the provision of, Health and Disability Services in their district.

Prisoners have the same right to disability support services as the general public. Therefore, if an elderly prisoner were in need of a walking aid, Health Services staff would contact their respective DHB for assistance. As with people in the wider community, there may be eligibility criteria, so prisoners may not automatically receive the required assistance.

Hospice care can be provided to prisoners, but it is geared toward terminal illnesses. Prisoners only become eligible if there is a prognosis of about six months or less to live. There are no specific policies that mention how to care for prisoners with age-related conditions such as Alzheimer's disease or dementia, or the health management of prisoners who require palliative care.

The Health Services Manual does not contain a general policy regarding the care and management of prisoners who suffer from an age-related condition. However, it is recognised at a local level. There is an awareness of this problem, but with neither standard guidance and policy nor targeted funding, individual staff in individual prisons are simply doing what they can with available resources.

Some prison units we visited cater for frail and aged prisoners well. One particular unit has a nurse on duty throughout the day and prisoners are free to discuss their health concerns, seemingly without the need to submit a health request form. The oldest prisoner in the unit is 86 years of age. These units were established because of the number of prisoners needing more specialist care, rather than any departmental policy or strategy regarding the management of elderly prisoners.

We see nothing wrong in the current way Prison Services staff manage frail and aged prisoners at a local level. However, it is important that the Department develops an overarching strategy and implements consistent management practices and protocols.

We recommend that the Department develop a national policy regarding the healthcare management of frail and aged prisoners.

In its response to the Draft Report, the Department said:

"The Healthcare Pathway Policy and Procedures describes the expectations for care for all prisoners with health needs, including those with complex health needs such as frail and aged prisoners. Appropriate management of prisoners with complex health needs is a priority in the current Health Services work plan, and this has been discussed by the Prison Services Management Team as a broader Prison Services issue. The Department is working with the Ministry of Health to ensure appropriate management of prisoners with complex health needs."

(c) Physically Impaired Prisoners

Physically disabled prisoners are few in number but they face significant problems in prison.

The Department told us that some prisons have designated cells for disabled prisoners. Those with a high level of physical incapacity could attend Health Centres with a specially fitted-out “disabled bathroom”.

In general terms, however, prison buildings and amenities do not support the needs of such prisoners. Prison doorways are narrow, and there is a lack of ramped access to visitors’ areas. There is a lack of handrails, special furniture and equipment. Access to staff in control rooms for disabled people is difficult. Disabled prisoners may require non-standard beds, mattresses and chairs.

A disabled prisoner in an electric wheelchair told us that on occasions when he was incontinent he did not receive timely or appropriate assistance. The prisoner said:

“I had an incontinence accident and did not receive any help to change my clothing. What I had to do was clean them up with toilet paper and I placed a towel of theres (sic) in my underwear to protect as much as possible and give me some comfort. I told them of the incident but they did nothing.”

The prisoner also complained that the prison was unable to cope with his required dressings for severe leg ulcerations. Outside prison he said he received daily dressings, but within the prison this only occurred 3 times a week. He also complained about the lack of bio-hazard laundry bags for washing soiled laundry.

In the prison unit where the prisoner was eventually placed, there was an absence of ramps to ease the transition between low and elevated surfaces. Getting in and out of doorways was difficult. Using a standard toilet was also difficult. Toilets for the disabled have a higher bowl and cells are not equipped with these.

Some adaptations to the physical environment, such as the installation of ramps, have been carried out at some prisons. At Rata Unit, Waikeria Prison, a 20-bed alcove area adjacent to the larger 60-bed unit area with wooden ramping provides better mobility for prisoners. Unfortunately, this was not completed due to budgetary constraints.

On 26 September 2008, New Zealand ratified the UN Convention on the Rights of Persons with Disabilities (the Convention). The purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

The Convention does not create new rights for disabled people. Instead, it builds on conventional understanding of what is required to implement existing human rights as they relate to disabled people.

The Ombudsmen are named as one of the independent entities that will, together with the Human Rights Commission and the Convention Coalition, take on the roles of promoting, protecting and monitoring the implementation of the Convention in New Zealand.

Essentially, the Ombudsmen's primary function will be to carry out specific elements of the protection and monitoring roles required by the Convention, in terms of:

- receiving, and where appropriate, investigating complaints from affected individuals or groups about the administrative conduct of State sector agencies, which relate to implementation of the Convention; and
- initiating own-motion investigations in relation to the administrative conduct of State sector agencies in implementing the Convention, where that conduct (including lack of action) affects persons with disabilities.

The Convention provides that the ratifying States must ensure the full realisation of all human rights and fundamental freedoms for all disabled people, on an equal basis with others, and without discrimination of any kind on the basis of disability.

The provision of the healthcare services for persons with disabilities is found in Article 25 of the Convention. The Article states:

"States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- a. Provide persons with disabilities with the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;*
- b. Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;*
- c. Provide these health services as close as possible to people's own communities, including in rural areas;*
- d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private healthcare;*

- e. *Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;*
- f. *Prevent discriminatory denial of healthcare or health services or food and fluids on the basis of disability."*

With specific reference to prisoners, Article 14(2) of the Convention states:

"States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation."

The Department's legislation and policy must be consistent with the principles set out in the Convention.

We recommend that the Department take steps to identify any gaps in the current care provided to physically impaired prisoners, in line with New Zealand's obligations under the United Nations Convention on the Rights of Disabled Persons.

In its response to the Draft Report, the Department said:

"The Prison Health and Disability Support Service specifications set out the healthcare to be provided to prisoners. The Department will further consider its obligations under the United Nations Convention on the Rights of Disabled Persons."

(d) Pregnant Prisoners

(i) Maternity care

Pregnant women have special health and dietary needs. Pregnancy, of course, is not an illness but a normal biological process. Nevertheless, every pregnancy has some risk of health problems and an expectant mother should reasonably have monitoring available from a health professional. Expectant prisoners are more likely to experience high-risk pregnancies due to previous inadequate healthcare and substance abuse.

At the Auckland Region Women's Corrections Facility, pregnant prisoners are cared for by nurses and the prison's Medical Officer until the 15th week of their pregnancy. At this stage they are referred to a midwife who visits from the Counties Manukau DHB. This midwife oversees their care, and in some instances, assists in the birth of the baby. The midwife also visits mother and baby up to six weeks post-natally.

All pregnant women are taken off-site for the following scans:

1. Dating Scan - as soon as possible to determine the estimated date of delivery;
2. Leucal translucency scan at 10 – 13 weeks + 6 days (prisoners have a blood sample taken at this time as well); and
3. Anatomy scan at 18 – 20 weeks.

At Christchurch Women's Prison, the prison manager advised:

"The Social Worker completes an assessment on pregnant women to assess their suitability for keeping the child in their care once born. This assessment takes into account any care and protection issues that CYFS may have and identifies alternative caregivers in the community that we can call on for any changes of circumstances, ie mother using drugs or mis-treating the child etc. that may occur and it is not considered to be in the best interests of the child to remain with the mother. To date we have not experienced any of these issues.

Recently Social Work and Health have worked with a community agency to provide information and support for pregnant prisoners in the form of ante-natal information, these sessions are delivered to individuals or to groups depending on the need. Midwifery care is arranged via the health Unit, it is my understanding that the midwife is involved for six weeks after the birth and then the women have a choice of a 'well child' provider, either Plunket or Tamariki Ora."

He went on to say:

"All pregnant prisoners are placed on a special diet to minimise the risk of contracting food poisoning. They are not given additional dietary supplements, unless the need for them is indicated through blood test results."

At Arohata Prison, pregnant prisoners on reception are referred to the prison's Social Worker. The Social Worker arranges with Porirua Union Midwives for a midwife to visit. Prisoners who are pregnant have the same access to the Lead Maternity Carer (LMC) system as any other women in the community. The LMC is funded by the Ministry of Health and ensures pregnant women have access to healthcare throughout their pregnancy and for 4-6 weeks after the birth of their baby. The prison has a responsibility to facilitate this process.

Health Services are involved in the general healthcare of pregnant mothers, but more specialised care is provided by a midwife. If the prisoner has complications of pregnancy/labour she would be seen and treated by an obstetrician.

Arohata Prison management staff told us that careful consideration is given to the placement of expectant mothers within the prison.

In our view, it appears as though the health needs of pregnant prisoners are well catered for by the Department.

(ii) Post-natal care

In 2002, the Department introduced a policy that allowed babies under 6 months of age to live with their mothers in self-care units in prison. Self-care units are residential-style accommodation units designed to be used primarily by selected prisoners who are nearing release and who have specified identified re-integrative needs, and by prisoners with babies. The units assist in the reintegration from prison to community by reducing the gap between the prison environment and the community.

The Parole Act 2002 allows the New Zealand Parole Board to grant early release on compassionate grounds to a prisoner who has given birth during her sentence. Prison management first assesses the offender's suitability taking account of security classification, welfare of offender and child and the views of Child, Youth and Family. A report will then be submitted to the Parole Board for decision.

In 2006, the Corrections (Mothers with Babies) Amendment Bill was introduced to Parliament. The Bill had two goals. First, to ensure that the Department allowed mothers to breastfeed in prison; and second, to extend the period during which mothers could keep their child in prison from 6 months to two years. The Bill was passed by Parliament in 2008. The Act inserts a new section 81A in the Corrections Act. It provides:

"Request and approval for placement of child with mother the day after the date on which the child turns 24 months if she –

(1) A female prisoner who is the mother of a child less than 24 months old, or who is expecting a child, may request the chief executive's approval to keep the child with her until

- (a) was the child's primary caregiver before being imprisoned or is likely to be the child's primary caregiver on release;*
- (b) does not have a conviction for an offence involving sexual or violent offending against children; and*
- (c) agrees to undergo screening for the purposes of identifying any mental health and substance abuse issues."*

The date on which the amendments were to come into effect was deferred. This was because the alteration of existing facilities and construction of new facilities (deemed necessary by the Department) had yet to be allocated funding. However, in September 2011, we were advised by the Department that it has funded the required capital and operating costs to increase the number of beds (4 at Christchurch Women's Prison and 6 at Auckland Regional Corrections Facility) to support the extension of the age range to two years that prisoner mothers can apply to have their baby with them in prison.

While in prison, a mother is responsible for the care of her child. However, the Department will provide parenting information, attend to arrangements for the child to receive any necessary health and wellbeing checks, and facilitate the mother's access to *"any treatment or counselling required to support the mother to care for her child"*.

The prison manager at Christchurch Women's Prison advised:

"Women who are approved to care for their baby in the prison or are to be released in the Canterbury area, can consent to a referral to the Family Help Trust. FHT are able to engage with the women four months prior to the birth and stay involved until the child is five years old. They provide a parenting and support programme/ service where a social worker visits the woman once a week. This service then provides through care, family support, and ongoing monitoring of the baby's welfare. FHT have developed a programme (New Start Plus) and workbook particularly for women parenting in prison. Prisoners who decide to keep their baby with them in prison can seek approval to care for their baby at the prison's self-care unit".

At Arohata Prison, however, the self-care unit at the time of our investigation was closed. If a mother did not want her newborn child to be cared for in the community, usually with family/whanau, and wished to remain with her child, she would be required to transfer to either Christchurch Women's Prison or Auckland Region Women's Corrections Facility.

It is unreasonable, in our view, for a mother, with sound reasons for being housed in a particular location and in prison, to be transferred to another prison. This amounts to a health issue that was not in the best interests of the mother or baby.

Although Arohata Prison did not receive any funding for additional facilities to support mothers with babies, the self-care unit at the prison is no longer closed. The unit is able to cater to the needs of mothers and young babies, however when the child is at an age where he/she needs playground equipment and more space in which to roam, consideration is then given to transferring mother and baby to either the Auckland Region Women's Corrections Facility or Christchurch Women's Prison.

Chapter 20 - FUTURE OPTIONS FOR THE FUNDING OF HEALTH SERVICES

A Health Report titled *“Options for Funding and Delivering Health Services to Offenders”* was presented to the then Minister of Health, Hon Peter Hodgson, in 2007. Concerns had been raised as to whether prisoners in New Zealand receive Health Services that are reasonably equivalent to those provided to the wider community.

The Ministry of Health, in consultation with the Department of Corrections, Ministry of Justice, District Health Boards and other key stakeholders investigated:

- “1. Whether or not offenders are receiving a service which is reasonably equivalent to the wider community and, if not, what are the major gaps in services; and*
- 2. Whether alternative methods for funding and delivering services to offenders will lead to improved service delivery and better address the high and complex needs of this population group.”*

In respect to (1) above, the Ministry identified gaps where services were not being provided at all, and areas where services were being provided, but not to a level sufficient to meet the demand for service.

Three options were ultimately put forward to deal with the perceived difficulties:

(Option 1) Retain the current Department-delivered prison Health Service, but with improvements in service efficiency and delivery;

(Option 2) Transfer responsibility to DHBs with prisons in their area; or

(Option 3) Transfer to a stand-alone organisation that would provide Primary Healthcare Services itself, or contract with providers (e.g. Primary Health Organisations) to deliver services to prisons.

At a later date, another option (Option 4) was put forward. The option proposed that prisoner health services should be transferred to five lead DHBs. The eventual report did not include an examination of the benefits or otherwise of this option.

The report commented on the benefits or otherwise of the three main options put forward.

Information on different models in use in England/Wales, New South Wales and France was presented. However, international jurisdictions had conducted no research, and there was no empirical evidence on the benefits and risks of those models. In the absence of this information, officials identified the current Department-delivered Health Service as the preferred option.

Paragraph 112 of the report stated:

"None of the options assessed above as reform end points in their own right are demonstrably superior to the others. However, continuing with the current arrangements, without reform, is unlikely to be sustainable in the longer term. The absence of a clearly superior option coupled with an absence of information needed to assess and to address the management of the fiscal risks associated with options two and three, suggests that it would not be appropriate to move directly to either of these options."

The Ministry of Health's view was that prison health services would be best delivered by the health sector in the longer term. The Ministry said:

"...given the uncertainty around the risks relative to benefits associated with options two and three, officials' preference is to proceed with the enhancements suggested under option one but with a commitment to report back to Government by 2010 on the success or otherwise of the changes in addressing the issues highlighted above and with advice on the risks and benefits of moving to a health-managed model under either options two or three (or a variation on those). The establishment of a joint sector council provides opportunities to increase health sector involvement in current and future service delivery arrangements and will promote a more integrated approach across the health/corrections sectors."

The Memorandum of Understanding between the Ministry of Health and the Department has brought Health Services closer in line with Ministry of Health strategies. However, Health Services, in our view, cannot be considered to be organised in close relationship with the "general health administration of the community or nation" as stated in Article 22 (1) of the United Nations Minimum Standard Rules for the Treatment of Prisoners.

Article 22 (1) states:

"At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship with the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality."

The Health Services budget, for example, is determined by the Department, rather than the Ministry of Health. Also, the Health Services budget is not ring-fenced, and therefore, if custody budgets are over-committed, pre-agreed health budgets can be reduced. Prison nurses are employees of the Department of Corrections and are generally viewed by prisoners as Corrections staff. The National Health Manager reports to the General Manager of Prison Services, rather than the Director-General of Health or Minister of Health. There is no wider health oversight of Health Services operations. Furthermore, there is no doctor or dentist representative attached to the Department's National Health Services team to give guidance in the development of health policies and procedures. Officials from the Ministry of Health do not provide oversight of Health Service operations.

The Department's Health Services is not a Public Health Organisation. Prisoners are ineligible, for example, for Public Health Organisation-funded services such as Care Plus. Care Plus is a service for people assessed by a doctor or nurse as benefiting from intensive clinical management. To be eligible for Care Plus, a patient must be enrolled with a Public Health Organisation.

Our investigation leads us to have considerable concern that the expected pressure of increased prisoner numbers and difficulties in the recruitment and retention of nurses (and in some cases Medical Officers and dentists) will undermine the ability of Health Services to effectively meet the health needs of prisoners. The existing Department-delivered model may not, in the long term, be financially and organisationally sustainable.

Our report has highlighted a number of concerns with regard to the Department's provision of health services for prisoners. They are not insurmountable. However, we strongly urge that the Department's Health Service should be aligned with the wider health system. Health Services for prisoners should be funded and delivered by an agency whose primary focus is "health" and therapeutic support, not custodial services.

In its response to the Draft Report, the Department said:

"As it has in the past (notably the Health of Offenders project), the Department will continue to work with the MoH to consider various options for the future delivery of health services within prisons, and is currently working with the MoH to respond to the NHC report. However, we are firmly of the view that, at this time, prisoner health services should be delivered by a dedicated prisoner, health service within the Department."

In the circumstances, we can only note the divergence of view between ourselves and the Department.

Chapter 21 - SUPPORT FOR AND RECOGNITION OF NURSES

(a) General Comment

The skill and knowledge of nurses are vital components in maintaining and delivering a high standard of primary healthcare to prisoners.

At various sites we visited, some nurses felt that they were not supported and their nursing skills and qualifications were generally not recognised. Some spoke of an “*us and them*” culture between Health Services and custodial services. If an error regarding the health needs of a prisoner were to be made, nurses felt as though a “*witch-hunt*” would ensue.

Nurses spoke about a sense of isolation, not just from the general community of nurses, but sometimes also from their own nursing and custodial colleagues. Health Centre Managers spoke about the inability to attract nurses in some regions, and the lack of sufficient staff to provide adequate cover in the event of staff sickness or other unexpected absence.

The role of nurses within prison Health Services is not directly recognised in legislation. Neither the Corrections Act 2004 nor the Corrections Regulations 2005 refer to the role of nurses. Nevertheless, it is nurses who are invariably the first point of contact prisoners have with Health Services, and nurses provide the majority of healthcare and treatment of prisoners.

Health Services is also not featured in the Department’s annual reporting. However unintentioned, we feel this shows a lack of recognition of Health Services in the wider aspects of the Department’s work. It also disallows Health Services the opportunity to showcase many of the positive locally-based health initiatives that are being developed and which could be usefully rolled out throughout the system.

An initiative such as the Health Navigator Programme is an example of this. The programme was introduced by the Whanganui Regional Health Organisation in 2009. Prison Health Services staff work closely with community providers to ensure a continuity of care for prisoners when they are released. Prisoners, before their release, are visited by a “health navigator” (community health worker) and a wellness plan is developed. The plan may include aspects of health, housing, life skills and training options. Health navigators then assist ex-prisoners to access primary healthcare and other services in the community.

(b) Continuation of Health and Disability Sessions

Staff from the Health and Disability Commissioner’s Office ran workshops in a number of prison Health Centres during 2009. The aim was to address issues between custodial and Health Services that impacted on their ability to work effectively. Our understanding is that not all prisons were visited.

The National Health Manager said: “*The workshops proved very useful in getting nurses to think about how they and their team act, and how this impacts on their ability to meet the health needs of prisoners.*”

Our view is that provision of good healthcare for prisoners depends on the effective functioning of teams. We commend the concept of the workshops.

(c) The Need for Professional Supervision

Mental Health Nursing and its Future: A Discussion Framework (Ministry of Health, 2006) described professional development as:

“...a formal process that provides professional support to enable practitioners to develop their knowledge and competence, be responsible for their own practice and promote service users’ health outcomes and safety...[this involves] time away from the practice environment to meet with an experienced practitioner of their choice to engage in guided reflection on current ways of practising.”

The Discussion Framework recommended that the strengthening of the nursing workforce is integral to the provision of services to mental health and addiction service users. It prioritised professional supervision as one of its nine recommendations in order to achieve this aim.

Furthermore, the Health Practitioners Competence Assurance Act 2003, with its emphasis on maintaining standards of practice to ensure public safety, requires mental health and addiction nurses to demonstrate that they are “competent and fit” to practise. Professional supervision is a critical component in this regard.

We would define professional supervision as a professional and supportive relationship between two or more people, one of whom is a qualified supervisor. It is a recognised tool that enhances therapeutic relationships, promotes professional development and is useful for problem-solving.

The prison environment is challenging, diverse and sometimes replete with aggressive behaviours. Prison nurses are isolated from mainstream nursing services, and they cannot easily rely on wide collegial support.

We were surprised that the Department does not fund professional supervision for prison nurses. Nurses, at their own expense, can undertake supervision, and at one prison we were told that a nurse had paid for her own supervision for five years.

We recommend that the Department give consideration to the provision of departmentally-funded professional supervision for Health Services staff.

In its response to the Draft Report, the Department said that the funding for professional supervision is not currently available. The Department has said that the on-going development and support of Health Services staff is very important. While we are mindful of this, our view is that Health Services staff must be provided with departmentally-funded professional supervision that increases feelings of support, personal wellbeing and morale. Supervision must be seen as a vital component of a wider commitment of the Department to foster a health service that ultimately improves outcomes for prisoners and reduces stress and burn-out of staff.

(d) The Role of Health Centre Manager

Prison nurses are required to have performance management plans under the Department's Performance Management System, but these plans are not specifically clinical in nature.

While nurses are registered under the Health Practitioners Competence Assurance Act 2003 and their ongoing competence and fitness to practise is the responsibility of the Nursing Council of New Zealand, clinical competence on a day-to-day basis is the responsibility of Health Centre Managers. From the comments of Health Centre Managers themselves, they rarely assess nurses' clinical competence. Health Centre Managers said they were too overburdened in routine nursing duties, including providing cover for illness or other absence.

We consider that it is important for Health Centre Managers to provide strong clinical leadership. To do this, they must be provided with the resources necessary to allow capacity for the systematic clinical and administrative assessment of all nurses.

We recommend that the Department review the role of Health Centre Manager with the aim of ensuring that staff appointed to this position are provided with the necessary capacity to be able to assess the competency of nursing staff on a regular basis.

In its response to the Draft Report, the Department said:

"The need to review nurse position descriptions and performance management systems is a priority in the current Health Services work plan. This work will be completed in 2011. Health Services nurses must be Registered Nurses and therefore must meet the competency requirements of the Nursing Council on an annual basis."

Chapter 22 - CONCLUDING COMMENTS

Prisoners, in the main, either remarked that Health Services were woefully inadequate, or they praised the care and attention afforded by nursing staff and/or the Medical Officer.

Health Services staff were particularly open and honest with their comments and we thank them for this. Throughout the investigation we were impressed by the dedication of nursing staff, medical officers and dentists who work to deliver services in often difficult circumstances. In spite of their heavy workload and the restrictions of the prison environment, they strive to meet the health needs of prisoners. This is sometimes against the backdrop of limited financial resources, outdated equipment and unsuitable facilities.

Accessibility of healthcare was generally good. Prisoners have rapid access to primary care services, and relatively short waits for secondary care. The exceptions to this were dentistry (primary care) and forensic mental health beds (secondary care).

The International Covenant on Economic, Social and Cultural Rights (Article 12) states:

"The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

The Corrections Act 2004, section 75(1) states:

"A prisoner is entitled to receive medical care that is reasonably necessary."

The Memorandum of Understanding (MOU) between the Department of Corrections and the Ministry of Health (July 2004) outlines the desired outcomes for the purpose of providing healthcare to prisoners:

4.1.2 *"The health services to be provided to prison inmates will be the same standard as is provided to the general population of New Zealand."*

The basic premise of the three statements is that access to medical services should not be adversely affected by imprisonment.

Arrangements for the provision of health services to New Zealand prisoners are currently delivered by primary care teams employed by the Department of Corrections. In order to minimise conflicts of interest and maximise the autonomy of health services, our view is that health services should be located (in an organisational sense) outside the correctional agency.

Although we found some similarities between primary healthcare in prison and in the community, there were also differences. The prison environment itself poses a threat to mental wellbeing, prisoners cannot choose their healthcare team, and the transient population often means treatment is interrupted as prisoners are transferred or released.

We found prison healthcare to be reactive rather than proactive, with a lack of direction and poor lines of communication.

The Department's current provision of dental services is inadequate to meet the needs of prisoners.

Mental healthcare appeared inadequate or unsuitable. We found the boundaries between primary mental healthcare and secondary care blurred.

Arrangements for monitoring clinical competence and continuing professional development of healthcare staff were not always well established.

Throughout the body of our report we have commented on aspects of the Department's health service where current practices would not, in terms of the Ombudsmen Act, be unreasonable. Nevertheless, we have put forward a number of suggestions which we hope will improve the delivery of health services to prisoners, support Health Services in their day to day activities and also raise the profile of Health Services staff within the Department and wider nursing community.

Chapter 23 - SUMMARY OF SUGGESTIONS AND FORMAL RECOMMENDATIONS

Suggestions for Department to consider

We recommend that the Department give consideration to the following suggestions put forward in the report:

1. The Health Services Manual be made available to the public on the Department's website (**Chapter 1 - Background**).
2. The person responsible for the day-to-day management of Health Centre operations should be afforded the title of Health Centre Manager (**Chapter 3 - The Department's Health Service**).
3. Develop a national data collection for prisoner's health information and to identify the health needs of the prison population (**Chapter 3 - The Department's Health Service**).
4. Encourage the on-going training of staff in suicide and self-harm reduction (**Chapter 6 – Self-Inflicted Deaths in the Department's Custody**).
5. Commission new research into the mental health of prisoners (**Chapter 6 - Self-Inflicted Deaths in the Department's Custody**).
6. Ensure that all nurses engaged in triage are fully and appropriately trained, and receive refresher courses on a regular basis (**Chapter 7 – The Department's Primary Healthcare Service**).
7. Site specific health information in hard-copy should be available to prisoners if kiosks are not operational (**Chapter 7 - The Department's Primary Healthcare Service**).
8. Health Services actively consider the times that medication is issued to prisoners to ensure that the optimum clinical benefit is achieved (**Chapter 7 – The Department's Healthcare Service**).
9. Identify any institutional barriers that preclude fuller involvement of specialist Alcohol and other Drug services in prison, especially as it relates to psychosocial intervention (**Chapter 7 - The Department's Primary Healthcare Service**).
10. Consider alternatives to registered nurses issuing medication (**Chapter 7 - The Department's Primary Healthcare Service**).
11. Canvass Health Services staff to identify if there are any outstanding issues or problems regarding the use of electrocardiographs (**Chapter 7 - The Department's Primary Healthcare Service**).
12. Review the dates that emergency drills have taken place to assess whether or not Health Services staff are adequately prepared in the event of a medical emergency (**Chapter 8 - Emergency Services**).
13. After-hours Health Services staff should have access to prisoners computerised health records (**Chapter 8 - Emergency Services**).
14. Develop a departmental protocol between Prison Services and Health Services that clearly establishes the inclusion of Health Services staff in post-incident debriefing sessions (**Chapter 8 - Emergency Services**).
15. Identify any barriers, either perceived or otherwise, that discourage health education in prisons (**Chapter 9 - Health Promotion and Preventative Strategies**).
16. Develop a national policy on health education for prisoners (**Chapter 9 - Health Promotion and Preventative Strategies**).
17. Review the Transferability Rating Index with a view to the adequacy of the questions relating to prisoners' health (**Chapter 13 - Custodial Support for Health Services**).

18. Remove any procedures and practices that unnecessarily impede prisoners' privacy (**Chapter 14 - Health Centre Operations**).
19. Develop a higher level of training for custodial staff in how to manage prisoners with severe personality disorder (**Chapter 15 - Prisoners with Mental Health Problems**).
20. Contract recognised general counselling services for prisoners (**Chapter 15 – Prisoners with Mental Health Problems**).
21. Include Health Services as a separate reporting section in the Department's Annual Report (**Chapter 21 – Support for and Recognition of Nurses**).

FORMAL RECOMMENDATIONS

Chapter 7 - THE DEPARTMENT'S HEALTH SERVICE

(a) Access to Health Services

We recommend that the Department:

1. Develop a standard health request process. One option may be the provision of a locked box for request forms.
2. Provide prisoners with written acknowledgement that their requests have been received and, if possible, advise when action is intended.
3. Devise a method by which appointment time data can be regularly collected and analysed for the purpose of assessing required Medical Officers' hours.
4. All prisoner health-related complaints be forwarded directly to the Health Centre Manager and that the Department institutes a specific health complaints function on IOMS.

(b) Medication

We recommend that the Department:

5. Assess the cost of medication wastage and consider ways to reduce the cost of unused medication.
6. Self-administration policy provides a consistency of approach across all prisons.
7. Identify and distribute a nationally agreed list of restricted medications. The list should not, however, preclude a Medical Officer from prescribing a particular type of medication for sound clinical reasons.
8. Re-institute comprehensive and full training for nurses in relation to Health Services policy and ring-fence the health budget.
9. Develop and implement a formal hand-over policy with hospital authorities.
10. Consider the feasibility of linking the MedTech system with community providers' electronic health records.

Chapter 8 - EMERGENCY SERVICES

(b) *The Checking of Equipment*

We recommend that the Department:

11. Review its policy regarding the weekly checking requirement at prisons with less than 150 prisoners.

(c) *Automated External Defibrillators*

We recommend that the Department:

12. Review the number of defibrillators at each prison. Consideration should be given to the number of prisoners and size of the prison site.
13. Train and permit custodial staff to use defibrillators.

(g) *Advanced Emergency Training for Custodial Staff*

We recommend that the Department:

14. Review the level of first-aid training for custodial staff.

(h) *Emergency Distress Calls*

We recommend that the Department:

15. Implement a standard emergency distress call with expediency.

(j) *Do Not Resuscitate*

We recommend that the Department:

16. Develop a Do Not Resuscitate policy.

Chapter 12 - DENTAL AND ORAL HEALTH

We recommend that the Department:

17. Consider expansion of the current dental service to reduce the length of time prisoners wait until they receive dental treatment

Chapter 13 - CUSTODIAL SUPPORT FOR HEALTH SERVICES

(b) *Uncertainty Regarding Roles and Responsibilities*

We recommend that the Department:

18. Require all prisons to develop Service Level Agreements that clearly establish the roles, responsibilities and expectations of Medical Officers, Health Services staff and custodial staff.

(c) *Transfers*

We recommend to the Department that:

19. Prisoners with a health alert on IOMS receive a health status clearance prior to transfer. This may include reviewing a prisoner's transfer in light of such things as counselling sessions or the input of extensive external Health Services.
20. If a Health Centre Manager is of the view that a prisoner's health may be compromised by transfer or that his/her needs cannot be met in a timely manner after transfer to another prison, a recommendation that the prisoner be excluded from transfer be made to the prison manager.
21. The Department ensures that health alerts are placed on IOMS.

(f) *Health Training for Custodial Officers*

We recommend to the Department that:

22. The role and responsibilities of Health Services be included as a separate syllabus topic taught to new Corrections Officers

Chapter 14 - HEALTH CENTRE OPERATIONS

(a) *General Description of Health Centres*

We recommend that the Department:

23. Give consideration to the refurbishment or relocation of older Health Centres.

(c) *Custodial "Runners"*

We recommend that the Department:

24. Examine whether or not the current provision of "runners" in prisons is sufficient to meet the health needs of prisoners.

(d) Procurement of Medical Equipment

We recommend that the Department:

25. Undertake an inventory of Health Services equipment at all sites to identify any shortfalls in the provision of such equipment. Should new or additional equipment be required, approval should be sought through the Department's usual process for procuring medical equipment.

Chapter 18 - PROVISION OF PROSTHESES FOR PRISONERS

We recommend that the Department:

26. Develop a nationally-consistent policy regarding the level of prisoner funding required before prostheses are purchased or prosthetic work is undertaken.

Chapter 19 - THE NEEDS OF CERTAIN GROUPS OF PRISONERS**(a) Transgender Prisoners**

We recommend that the Department:

27. Review its policy regarding the placement of transgender prisoners. For transgender prisoners who have not completed full sexual reassignment, consideration should be given to their placement in a women's prison, if it is their wish to do so.

(b) Aged and Frail Prisoners

We recommend that the Department:

28. Develop a national policy regarding the healthcare management of frail and aged prisoners.

(c) Physically Impaired Prisoners

We recommend that the Department:

29. Take steps to identify any gaps in the current care provided to physically impaired prisoners, in line with New Zealand's obligations under the Convention on the Rights of Disabled Persons.

Chapter 21 – SUPPORT FOR AND RECOGNITION OF NURSES

(d) *The Role of Health Centre Manager*

We recommend that the Department:

30. Give consideration to the provision of departmentally-funded professional supervision for Health Services staff.
31. Review the role of Health Centre Manager with the aim of ensuring that staff appointed to this position are provided with the necessary resources to be able to assess the competency of nursing staff on a regular basis.

ANNEX 1

Regulations 71-81 of the Corrections Regulations 2005

7.1 Prison to have a health centre

- (1) In every prison there must be an area set aside as a health centre.
- (2) The health centre must be equipped to provide the following facilities:
 - (a) emergency first-aid facilities;
 - (b) examination room facilities; and
 - (c) secure facilities to store medical supplies and medicines.
- (3) The health centre must, at all times, be available for any medical emergency.
- (4) All medical examinations conducted within the prison must be conducted in the health centre or a place approved by the chief executive as suitable for conducting medical examinations, unless the condition of the prisoner requires that the prisoner be examined or treated elsewhere.

7.2 Duties of chief executive

- The chief executive must ensure that -
 - (a) health centres are equipped and operated to provide adequately for the health needs of prisoners;
 - (b) the health needs of prisoners are promptly met, and that, as far as practicable, the physical and mental health of prisoners is maintained to a satisfactory standard;
 - (c) [Revoked]; and
 - (d) access to adequate medical treatment is available to meet the health needs of prisoners at any time.

Regulation 72(c): revoked, on 1 December 2008, by [regulation 6](#) of the Corrections Amendment Regulations 2008 (SR 2008/371).

7.3 Duties of medical officer

- (1) A medical officer of a prison must take all practicable steps to maintain the physical and mental health of prisoners to a satisfactory standard.
- (2) Without limiting subclause (1), a medical officer of a prison must -
 - (a) advise the chief executive of any prisoner who, in the opinion of the medical officer, requires -
 - (i) special treatment or attention by staff members; or
 - (ii) a modification in the management of that prisoner;
 - (b) if the chief executive requires, or the medical officer considers it necessary in the circumstances, advise the chief executive of the equipment, supplies, facilities, and personnel required -
 - (i) to equip and operate the health centre adequately; and
 - (ii) to provide for the health needs of prisoners adequately;
 - (c) ensure that medicine is administered to a prisoner in accordance with his or her medical needs;
 - (d) advise the manager of the prison so that the provisions of the Misuse of Drugs Act 1975 are observed; and
 - (e) advise the chief executive of any health and safety issues affecting any prisoner, classes of prisoner, or all prisoners.

- (3) If two or more medical officers are appointed or engaged for a prison, each medical officer has the powers or functions conferred or imposed on him or her by or under the Act or these regulations.
- (4) This regulation does not limit any of the functions or powers conferred or imposed on medical officers by the Act.

7.4 Chief executive to arrange for temporary replacement in certain cases

- (1) A medical officer must reasonably promptly inform the chief executive if for a limited time that medical officer is or will be unable to perform his or her duties under the Act or these regulations.
- (2) The chief executive must ensure that arrangements are made for a suitable medical practitioner to act in place of the medical officer during the time the medical officer is away.
- (3) While acting in place of the medical officer, the medical practitioner has all the powers and functions conferred or imposed on the medical officer.

7.5 Medical officer may arrange for additional medical assistance

- A medical officer of a prison may arrange for additional medical assistance in an emergency, but -
 - (a) must, if possible, consult the manager before doing so; and
 - (b) if it was not possible to consult the manager before doing so, must notify the manager reasonably promptly after doing so.

7.6 Certain prisoners at risk or seriously ill

- (1) A medical officer must promptly notify the chief executive in writing with any recommendations the medical officer thinks fit, if the medical officer has reason to believe that -
 - (a) a prisoner is at risk of self-harm;
 - (b) the physical or mental health of a prisoner has been or is likely to be injuriously affected by continued detention or by any conditions of detention;
 - (c) a sick prisoner will not survive his or her sentence or is totally or permanently unfit for detention; or
 - (d) a prisoner should be transferred to a hospital or psychiatric hospital or a secure facility.
- (2) A medical officer of a prison must ensure that special attention is paid to any prisoner who is -
 - (a) denied the opportunity to associate with other prisoners as a consequence of a segregation direction ; or
 - (b) placed in a cell under a penalty of cell confinement.

7.7 Medical officer may refer prisoner to health service provider

- (1) If satisfied that a prisoner detained in prison requires treatment by a health service provider, a medical officer or a staff member who is a nurse may refer the prisoner to a health service provider for treatment.
- (2) A health service provider must report to the medical officer or the staff member who is a nurse after a consultation has been completed in respect of a prisoner.

- (3) If a prisoner wishes to obtain treatment by a health service provider, but a medical officer or a staff member who is a nurse does not consider that a referral under subclause (1) is justified, the prisoner may obtain the treatment if -
 - (a) the manager is satisfied that the treatment can be obtained in a manner that meets the security requirements of the prison for the prisoner, and
 - (b) the prisoner pays for the cost of the treatment, and the cost of facilitating his or her attendance to obtain the treatment.
- (4) A medicine prescribed for a prisoner by a health service provider may be administered at the prison only with the approval of the medical officer, or under the instruction of a medical practitioner.
- (5) An accused prisoner who at the time of his or her reception to a prison is undergoing urgent treatment by a health service provider may be visited and treated by the provider if -
 - (a) the chief executive approves of the treatment; and
 - (b) the accused prisoner pays for the cost, if any, of the treatment.
- (6) In this regulation, treatment includes assessment.

7.8 Inspections by medical officers

- (1) The medical officer of a prison may, and if asked to do so by an inspector or an ombudsman or the chief executive, must, inspect and give a written report on the condition of the prison or any particular aspect of the prison as it affects the health of prisoners.
- (2) When subclause (1) applies, the medical officer -
 - (a) must give a copy of the report to the chief executive; and
 - (b) if a person other than the chief executive asked for the inspection, must give a copy of the report to that person.
- (3) In the case of a prison with two or more medical officers, the references in subclauses (1) and (2) to the medical officer must be read as references to one of them, designated by the chief executive for the purposes of this regulation.

7.9 Registered health professional, medical officer, or nurse may make recommendations

- (1) A registered health professional, a medical officer of a prison, or a staff member who is a nurse may make recommendations to any other staff members in respect of the health needs of a prisoner.
- (2) In making a decision in respect of a prisoner, a staff member must consider all relevant recommendations under subclause (1).
- (3) A medical officer of a prison may at any time give the chief executive written recommendations on the health of any prisoner, or on any matter relating to the health or safety of prisoners.

8.0 Chief executive to notify medical officers in certain cases

- The chief executive must ensure that a medical officer is notified promptly if -
 - (a) a prisoner's physical or mental health appears to require the attention of a medical officer;
 - (b) a prisoner has been placed under a mechanical restraint (unless the prisoner is being escorted outside the prison or a medical officer has recommended the use of the restraint); or
 - (c) a prisoner is being or has been restrained by means of a physical hold.

8.1 Dental services

- (1) The chief executive must ensure that -
 - (a) dental examinations, and any other dental treatment approved by a medical officer, are provided for prisoners free of charge to them; and
 - (b) a dentist is available to provide the examinations and treatment.
- (2) Any examination or treatment must be primarily concerned with the relief of pain, the maintenance of a reasonable standard of dental care relative to the dental and oral health of the prisoner concerned before the prisoner was admitted to the prison, or both.
- (3) Subclause (1) is subject to subclause (2).
- (4) In this regulation, dentist means a person for the time being registered as a dentist under the Health Practitioners Competence Assurance Act 2003.

ANNEX 2

United Nations Standard Minimum Rules for the Treatment of Prisoners - Articles 22-26

Medical Services

22. (1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organised in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.
- (2) Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.
- (3) The services of a qualified dental officer shall be available to every prisoner.
23. (1) In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate.
- (2) Where nursing infants are allowed to remain in the institution with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.
24. The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.
25. (1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.
- (2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.
26. (1) The medical officer shall regularly inspect and advise the director upon:
 - (a) The quantity, quality, preparation and service of food;
 - (b) The hygiene and cleanliness of the institution and the prisoners;
 - (c) The sanitation, heating, lighting and ventilation of the institution;
 - (d) The suitability and cleanliness of the prisoners' clothing and bedding;
 - (e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.
- (2) The director shall take into consideration the reports and advice that the medical officer submits according to rules 25(2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

ANNEX 3

Memorandum of Understanding Between the Department of Corrections and the Ministry of Health

This memorandum of Understanding is effective from 1 July 2004

Between: The Chief Executive of the Department of Corrections ("the Chief Executive")
And The Director-General of Health, Ministry of Health ("the Director-General")

BACKGROUND

The Ministry of Health was established under Schedule One of the State Sector Act as a government department, with effect from 1 July 1993.

The Department of Corrections was established by State Sector Order 1995/28, as a government department with effect from 1 October 1995.

For the purpose of this Memorandum of Understanding (MOU) a reference to the 'Parties' means the Ministry of Health ("the Ministry") and the Department of Corrections ("Corrections").

We Agree as Follows

1. Purpose

The purpose of this MOU is to:

- 1.1 Define the roles and responsibilities of the Ministry and Corrections in those areas where the two agencies have complementary responsibilities for protecting and enhancing the health status of prison inmates.
- 1.2 Facilitate co-operation between the Parties with the development of strategy, policy, communications, practice or procedure in areas that have the potential to affect the Parties' ability to enhance the health status of prison inmates.

2. Principles

The principles underpinning this MOU are:

- 2.1 The health needs of prison inmates should be effectively monitored and managed. This includes monitoring and managing the potential risks to the health of prison inmates.
- 2.2 Inter-sectoral and intra-sectoral collaboration and co-operation will occur to ensure that the health needs of the prison population are met.
- 2.3 There will be effective co-operation between the Ministry and Corrections, consistent with the government's expectation of a "whole of government" approach.
- 2.4 We acknowledge that we have some goals in common.
- 2.5 We will encourage our staff to meet these goals in a spirit of goodwill and co-operation, and in a consistent, professional, and culturally appropriate manner.
- 2.6 We will share information promptly and openly through a formalised process.
- 2.7 We will endeavour to resolve issues between us, in relation to the interpretation or performance of either of us under this MOU at the earliest opportunity.

- 2.8 We acknowledge that nothing in this MOU will override our accountabilities to our respective Ministers of the Crown.
- 2.9 We acknowledge each other's rights to refer any matter, policy, practice or procedure to our respective Ministers of the Crown.

3. Treaty of Waitangi

The Parties will adhere to their respective Treaty commitments outlined in He Korowai Oranga: Maori Health Strategy (Ministry of Health) and the Maori Strategic Plan 2003-2008 (Department of Corrections).

4. Outcomes

- 4.1 The desired high-level outcomes of this MOU are:
 - 4.1.1 Health services are to be made available for prison inmates at a level commensurate to that available to the general population of New Zealand.
 - 4.1.2 The health services to be provided to prison inmates will be the same standard as is provided to the general population of New Zealand.
 - 4.1.3 Prisons are accessible and disability aware environments.
 - 4.1.4 Prison inmates with disabilities should have access to appropriate support services commensurate to those services available to the general population of New Zealand.
- 4.2 Specific outcomes of this MOU include, but are not limited to:
 - 4.2.1 Improvement of the health planning process for prison health and disability support services.
 - 4.2.2 Defining the future direction for prison health and disability support services in New Zealand through the Joint Corrections Health and Disability Working Group (JCHDWG) (Schedule 1).
 - 4.2.3 Identifying how the Parties can make a positive impact on the current and future health status of New Zealand's prison population.
 - 4.2.4 Collaboration between the Parties in the development of lead projects.
 - 4.2.5 Development of protocols and guidelines relating to specific joint initiatives and responsibilities.
 - 4.2.6 Monitoring and review of agreed protocols and guidelines, including, but not limited to, the Prison Opioid Substitution and Detoxification Protocol (Appendix 2), the Operational Protocol on Victim Notification (Appendix 3) and the Service Level Agreement Guidelines for the Provision of Mental Health Services to Prison Inmates (Appendix 4).
 - 4.2.7 Assisting and supporting the development of Service Level Agreements between District Health Boards (DHBs), providers of prison services, the Community Probation Service and the Psychological Service.
 - 4.2.8 Resolving issues, which require further discussion between us, within agreed timeframes. Current issues requiring resolution are outlined in Schedule 2.

5. Roles and Responsibilities

Department of Corrections' Role

- 5.1 Corrections contributes to the government's key goals, with the primary focus being to contribute to safer communities by protecting the public and reducing re-offending.
- 5.2 Corrections contributes to safer communities by:
 - 5.2.1 Providing information to the judiciary to inform the sentencing process and to the New Zealand Parole Board to inform release decisions.
 - 5.2.2 Ensuring appropriate compliance with, and administration of, sentences and orders.
 - 5.2.3 Providing a safe environment for staff, offenders and the public.
- 5.3 Corrections works to reduce re-offending through the delivery of rehabilitative and re-integrative interventions. These also include the provision of education, work experience and skills, so that offenders are better equipped to secure employment on release from prison.
- 5.4 The Public Prisons Service is responsible for the safe, secure and humane containment of sentenced and remand inmates. The service is also responsible for managing the sentence needs of each offender, including responsivity, rehabilitation and reintegration programmes to help address the needs that contribute to offending.
- 5.5 The Community Probation Service manages community-based sentences and orders and provides information and reports to Courts and the New Zealand Parole Board to assist them in their decision making process. The Community Probation Service also provides responsivity and rehabilitative programmes to help address the needs that contribute to offending.
- 5.6 The Psychological Service provides specialist clinical assessment and treatment services to offenders and develops and delivers rehabilitative programmes. The service also undertakes psychological research, which helps to improve risk assessment, targeting and treatment effectiveness of offenders.

Department of Corrections' Responsibilities

- 5.7 Corrections funds and provides, either directly or through contract with external providers, primary healthcare (interpreted as including medical and nursing assessment, treatment and care and disability support services), pharmaceuticals, user charges, primary mental health (including alcohol and other drug) services, cervical screening, emergency health, dental care, health education and advice for prison inmates.
- 5.8 Exceptions to clause 5.7 are pharmaceutical subsidies, the GMS and well child services, which are funded and provided by DHBs and maternity services, which are funded by the Ministry.
- 5.9 Corrections' responsibilities for prison health and disability support services are detailed in the Prison Health and Disability Support Service Specifications (Schedule 3).

Ministry of Health Role

- 5.10 The Ministry is the government's primary advisor on health policy and disability support services.
- 5.11 The Ministry is the government's agent in the strategic management of the public health and disability system, and is responsible for ensuring this system works for New Zealanders.
- 5.12 The Ministry's ultimate aims are to improve the health of the population and encourage their participation to reduce health-status inequalities between population groups.
- 5.13 To achieve this, the Ministry must ensure that the health and disability system provides quality services in an effective and efficient manner.
- 5.14 The Ministry currently retains responsibility for funding maternity services, Public Health Services, Disability Support Services for people with long-term physical, sensory and intellectual impairments, some national Personal Health Services and some Mental Health Services.

Ministry of Health Responsibilities

- 5.15 Prison inmates who meet the Ministry's definition of a person with a disability will have access to Needs Assessment and Service Co-ordination Agencies directly funded by the Ministry.

District Health Boards Role

- 5.16 The New Zealand Public Health and Disability Act 2000 established DHBs as both funders and providers of Health Services.
- 5.17 DHBs provide for the health needs of their local populations and the disability support needs of most people over 65, those people considered close in interest to older people (aged 50-64) and those with psychiatric disabilities, within resources made available by the government.

District Health Boards Responsibilities

- 5.18 DHBs have responsibility for funding specified Health Services including, most Personal Health (except primary health services in prisons, interpreted as including, medical and nursing assessment, treatment and care and disability support services), oral health, Maori health (except Maori provider development), specialist mental health (including forensic alcohol and other drug) services, and secondary and tertiary health services. DHBs also provide a range of community, secondary and tertiary services directly.

Eligibility

- 5.19 Prison inmates will be subject to the same Clinical Priority Access Criteria for publicly funded elective services as the general population. Referral, assessment and management guidelines are available on the Ministry of Health website www.moh.govt.nz.
- 5.20 The Ministry and DHBs fund services (other than primary health services for prison inmates) for eligible people according to the obligations set out in the Service Coverage Schedule (Schedule 4).

6. Population Approach

- 6.1 The Ministry and DHBs take a population approach to identify areas where intervention will make a contribution to improve the health of a population.
- 6.2 An aggregate population may be a specific population and a population approach involves assessing a population to identify opportunities to improve the overall health status and participation of that population.
- 6.3 Working to improve the health of a population means connecting all areas of service delivery (Public Health Services, Personal Health Services, mental health, and Disability Support Services) to respond as a whole system to changes in priorities or new evidence.

7. Public Health and Preventative Services

- 7.1 The health sector has explicit responsibilities under legislation to deal with public health and prevention issues on a “whole population” basis because of the impact on the wider population, even if a relatively small group is affected.
- 7.2 At times Corrections might have responsibilities either under its primary health obligations or its own strategic goals, such as “safe, secure and humane containment”, to deliver preventative services. If that eventuates specific projects are developed to reflect those obligations, such as the Harm Minimisation Project undertaken in Rimutaka and Arohata prisons and the Communicable Diseases Screening, Assessment and Treatment Project undertaken at Christchurch Men’s Prison.

8. Limitations of this MOU

- 8.1 Nothing in this MOU is intended to interfere with our obligations independently and co-operatively to comply with all relevant legislation; government and ministerial policies; and with the purchase agreements we have entered into with our respective Ministers of the Crown.
- 8.2 The provisions in this MOU are to be read subject to any Chief Executive, government, ministerial or Cabinet policy or directives, and any relevant Act, Regulation, Code and Guideline, including, but not limited to the:
 - Criminal Justice Act 1985
 - Criminal Procedure (Mentally Impaired Persons) Act 2003
 - Health Act 1956
 - Health and Disability Commissioner Act 1994
 - Health and Disability Services (Safety) Act 2001
 - Health Information Privacy Code 1994
 - Human Rights Act 1993 and Regulations
 - Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
 - Medicines Act 1981 and Regulations 1984
 - Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992, Ministry of Health 2000
 - New Zealand Public Health and Disability Act 2000
 - Parole Act 2002

- Penal Institutions Act 1954 and Regulations 2000
- Privacy Act 1993 and Regulations
- Sentencing Act 2000
- Victims Rights Act 2002

and any enactment passed by way of amendment or replacement of those listed above.

- 8.3 Where there are changes to government policy, which affect the purpose and functions of this MOU, we agree to inform each other of those changes at the earliest possible time thereafter and agree to meet to re-negotiate, if necessary, any aspects of this MOU.

9. Relationship Arrangements

- 9.1 The Chief Executive and the Director-General, will meet at least once each year to discuss the strategic direction, priorities and plans for the following financial year.
- 9.2 The responsibility for managing this MOU rests with our specified Relationship Managers. The Relationship Managers are the:
- Manager, Corporate Services, for the Department of Corrections, and
 - Manager, Public Health Programmes, for the Ministry of Health.

10. Schedules and Appendices

- 10.1 New Schedules and Appendices may be developed and added with approval from the General Manager, Corporate Management (GM CM), Department of Corrections, and the Deputy Director-General, Public Health (DDG PH), Ministry of Health, or their delegated staff.
- 10.2 Reviews, modifications, or terminations of existing Schedules and Appendices may be undertaken by the mutual agreement of the Relationship Managers.
- 10.3 All changes must be notified to the GM CM and the DDG PH, or their delegated staff, so that the master document can be amended.
- 10.4 Schedules and Appendices will be reviewed initially one year after signing and then every two years, or as agreed in writing between the Parties, in line with the reviews of this MOU.
- 10.5 We will develop roll-out plans in a timely manner to operationalise agreed national policies, programmes, guidelines and/or additional protocols agreed as Schedules of this MOU.
- 10.6 The roll-out plans will include roles, responsibilities, timelines, and completions.

11. Monitoring this MOU

- 11.1 For the purposes of monitoring the performance of this MOU, the Parties' Relationship Managers will implement a monitoring and reporting system within six months of signing.
- 11.2 Our Relationship Managers will meet at least every six months. The meetings will cover issues and developments relating to the operation of the MOU and other related matters.
- 11.3 Where agenda items require it, specialists from either agency will attend the meetings.

12. Communication and Media Strategies

- 12.1 We have established an agreed Communication and Media Protocol to support the delivery of effective communications covering areas of interest to either of us. (Appendix 1).
- 12.2 The protocol sets out the process that we will adopt around the following principles:
 - 12.2.1 At national level we will inform each other of relevant communication strategies that either of us are carrying out in relation to key activities, at the initial stage of development.
 - 12.2.2 Where appropriate, opportunities for joint communication campaigns should be taken at national, regional or district levels.
 - 12.2.3 We will consult with each other beforehand if either of us is considering providing information or comment to the media on a matter which comes within the other Party's responsibility, or in which that other Party has an interest that sits outside the arrangements agreed to in the Communication and Media Protocol.
 - 12.2.4 We will, for the purposes of clause 12.2.3, raise any operational or policy matters of concern through each other's appropriate internal channels and endeavour to resolve any differences prior to raising these through the media. These matters should be notified to our Relationship Managers.

13. Dispute Resolution

- 13.1 Resolution of any disputes, or issues arising between us, in relation to the interpretation or performance of the Parties under this MOU, shall be attempted by the Relationship Managers, or their delegated representatives, at the earliest opportunity.
- 13.2 We will endeavour to resolve issues raised, within 10 working days of receipt of notification in writing.
- 13.3 When matters remain unresolved from clause 13.1, or they require further adjudication, they should be referred to the JCHDWG for resolution within 15 working days.
- 13.4 When matters remain unresolved from clause 13.3, or they require further consideration, they should be referred to the Chief Executive and the Director-General for final resolution within 20 working days.

14. Variation

This MOU can only be varied by a written agreement signed by the GM CM and the DDG PH or their delegated representatives.

15. Contradictions

Where there is any contradiction between this MOU and a Schedule or Appendix, the terms of this MOU will prevail.

16. Review and Termination of this Agreement

- 16.1 This MOU will commence on 1 July 2004 and will remain in force until we agree to terminate it or unless earlier terminated by either of our respective Ministers of the Crown.

16.2 We will review this MOU at least once every two years.

16.3 We may amend it at any time by a further written agreement signed by us.

17. Our Representatives

Our specified addresses, facsimile numbers and representatives are:

17.1 **Ministry of Health**

Address: The Director-General of Health
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington 6145
Telephone: (04) 496 2000
Facsimile: (04) 496 2340

17.2 **Ministry Representative: Manager, Public Health Programmes**

Telephone: (04) 495 4370
Facsimile: (04) 495 4479

17.3 **Department of Corrections**

Address: The Chief Executive
Department of Corrections
Mayfair House
44-52 The Terrace
Private Box 1206
Wellington 6140
Telephone: (04) 499 5620
Facsimile: (04) 460 3207

17.4 **Corrections Representative: Manager Corporate Services**

Telephone: (04) 460 3314
Facsimile: (04) 460 3212

18. Interpretation

"Agreement" means this MOU including the attached Schedules and Appendices.

"Appendix" means any Appendix attached to this MOU and which is currently in force.

"Clinical Priority Access Criteria" means the criteria used to assist specialists in assessing relative patient need and ability to benefit from treatment.

"District Health Boards (DHBs)" are organisations named in Schedule 4, and established under section 19 of the New Zealand Public Health and Disability Act 2000.

"Disability Support Services" includes goods, services, and facilities:

- (a) Provided to people with disabilities for their care or support or to promote their inclusion and participation in society, and independence; or

- (b) Provided for purposes related or incidental to the care or support of people with disabilities, or to the promotion of the inclusion and participating in society, and independence of such people.

“Health Services” means primary, secondary and tertiary services including specialist consultations, mental health services, alcohol and other drug treatment and problem gambling interventions.

“Local Service Agreement” means any agreement in force between a Provider of Prison Services and a District Health Board, or other provider, for the provision of Health Services.

“Mental Health Services” includes goods, services and facilities that provide, as its core activity, assessment or treatment or support to people with identified mental illness or mental health problems and/or alcohol and other drug problems.

“Parties” means the Department of Corrections and the Ministry of Health and Party means either of them.

“Penal institution” refers to any prison or police jail established under the Penal Institutions Act 1954.

“Prison Inmate” refers to any person for the time being in the legal custody of the superintendent of any institution (does not include home detainees).

“Provider of Prison Services” means either the Public Prisons Service of the Department of Corrections or other providers of prison services contracted by the Department of Corrections during the term of this MOU.

“Personal and Primary Health Services” means goods, services and facilities provided for the purpose of improving, promoting, or protecting population health (rather than individual health) or preventing population-wide disease, disability, or injury, and includes:

- (a) Regulatory functions relating to health or disability matters;
- (b) Health protection and health promotion services; and
- (c) Goods, services and facilities provided for related or incidental functions or purposes.

“Schedule” means any Schedule attached to this MOU and which is currently in force.

“Relationship Manager” means the Ministry Representative referred to in clause 17.2 and the Corrections Representative referred to in clause 17.4.

“We/Us/Our” means the Chief Executive and the Director-General.

ANNEX 4

Protocol between the Ministry of Health and the Department of Corrections

Management of Prisoners Requiring Secondary Mental Health Services and Hospital Level Care

1. Purpose

- 1.1 This Memorandum of Understanding (MoU) outlines the expectations of the Department of Corrections and the Ministry of Health in respect of the management of prisoners assessed as having acute mental health needs, and seeks to minimise any potential risk that may arise while these prisoners are awaiting transfer from a Department of Corrections facility to a District Health Board hospital facility.
- 1.2 The primary focus of this MoU is on ensuring an acutely mentally unwell prisoner has access to the required level of healthcare and appropriate facilities.
- 1.3 The Ministry of Health is the ultimate funder of the provision of forensic mental health services via District Health Boards (DHBs) through Regional Forensic Psychiatry Services. DHBs are the direct funder and contracting party for these services. It should be noted that the Ministry of Health is not contractually in a position to enter into a service level agreement with the Department of Corrections.
- 1.4 It is proposed that regional agreements (either in the form of a service level agreement or a protocol) are entered into at a regional level between Regional Forensic Psychiatry Services, and regional Prison Services, on a nationally consistent basis which reflect the issues highlighted in this MoU.

2. Guiding Principles

- 2.1 The overarching principle is that a prisoner should not be disadvantaged from any other person in the community in accessing forensic mental health services by virtue of their residence in a prison. The following principles guide the provision of forensic mental healthcare for prisoners:
 - (a) Prisoners need for mental healthcare should govern their access to services;
 - (b) Prisoners should be accommodated in facilities that match their need;
 - (c) Prisons are not the most appropriate environment to assess and treat acutely mentally unwell prisoners;
 - (d) Prisoners cannot be subject to compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 in prison;
 - (e) Every effort should be made for prisoners to be able to receive a level of care that is reasonably equivalent to that available to the general population of New Zealand;
 - (f) Prison Services are funded only to the primary health level;
 - (g) Prison Services only have a duty under the Corrections legislation to provide necessary health services to prisoners. The Corrections legislation and Health legislation require that the provision of secondary and tertiary health services (including secondary mental health services) are the duty of the DHB health services.

3. Authority

- 3.1 Nothing in the proposed regional agreements derogates from any legislative or regulatory obligations, constraints or other legal responsibilities on the involved parties.
- 3.2 The following Acts, Regulations and Department of Corrections policies and procedures will apply:
 - Mental health (Compulsory Assessment and Treatment) Act 1992;
 - Corrections Act 2004, Corrections Regulations 2005, regulations 8, 10, 72, 73, 76-77, 79-80;
 - Prison Services Policy and Procedures Manual A.16 Mental Health (National Policy).

4. Roles and Responsibilities

- 4.1 The Ministry of Health is responsible for setting policy. As the ultimate funder, the Ministry of Health sets agreements with DHBs covering services and responsibilities under legislation and monitors the extent to which DHBs comply with mental health sector standards. The Ministry of Health will take a role in resolving disputes between the Department of Corrections and DHBs when there is disagreement over the management of a prisoner's mental healthcare needs.
- 4.2 The Department of Corrections is responsible for the provision of primary healthcare to prisoners, including primary health and alcohol and other drugs screening. The Department of Corrections provides a limited number of offence related alcohol and drug treatment programmes for prisoners. The Department of Corrections does not provide any secondary health related alcohol and drug treatment programmes.
- 4.3 The Department of Corrections is responsible under the Mental Health (Compulsory Assessment and Treatment) Act 1992 for making an application referring prisoners for compulsory treatment when there are reasonable grounds to believe that a person may be mentally disordered.
- 4.4 DHBs are responsible for all secondary and tertiary mental healthcare to prisoners including health related alcohol and drug needs. DHBs provide mental health services via the Regional Forensic Psychiatry Services. Alcohol and drug services are provided via the Community Alcohol and Drug Services.
- 4.5 Regional Forensic Psychiatry Services are responsible for assessing prisoners referred under the Mental Health (Compulsory Assessment Treatment) Act 1992. The Regional Forensic Psychiatry Services are also responsible for ensuring a management plan is instituted for those referrals requiring psychiatric services. The management plan may involve ongoing treatment in prison or transfer to a psychiatric facility in accordance with the Act.

5. Management of Waitlisted Prisoners

- 5.1 Owing to the lack of available secure forensic beds and the high level of demand on secure forensic beds in the health system, Regional Forensic Psychiatry Services cannot guarantee there will always be a bed available for all prisoners with an identified need for inpatient assessment and/or treatment at the time the need is identified.

- 5.2 Prisoners with an identified need for inpatient assessment and/or treatment who cannot be immediately transferred to hospital will be placed on a waiting list. This waiting list is to be managed by Regional Forensic Psychiatry Services according to acuity, need and best health practice. Prisoners on this waiting list are hereinafter referred to in this MoU as “waitlisted prisoners”.
- 5.3 Waiting lists should be made available to the Department of Corrections and discussed on a weekly basis with identified Corrections managers.
- 5.4 In respect of waitlisted prisoners, the Department of Corrections will:
 - (a) Provide primary healthcare only;
 - (b) Continue to hold all waitlisted prisoners in prison under the care and direction of Forensic Mental Health Services until transfer to hospital if possible;
 - (c) Initiate assessment process under the Mental Health (Compulsory Assessment and Treatment) Act 1992 in consultation with the Regional Forensic Psychiatric Service;
 - (d) Ensure that the forensic mental health service is notified of waitlisted prisoners who have impending release dates or Parole Board hearing.
- 5.5 In respect of waitlisted prisoners, Regional Forensic Psychiatry Services will:
 - (a) Notify the Department of Corrections in writing if a prisoner may not be able to be referred under the Mental Health (Compulsory Assessment and Treatment) Act 1992 due to lack of availability of a secure forensic bed;
 - (b) Accept primary clinical responsibility for the assessment, treatment and care planning of waitlisted prisoners, and develop a management plan for each prisoner in consultation with Corrections;
 - (c) The aims of the management plan will be to minimise the likelihood of the prisoner doing harm to themselves or others, to provide support and advice to Corrections staff and encourage the prisoner to comply with any medication or treatment;
 - (d) Ensure the assessment and management plans are documented in the prisoners commensurate with their level of clinical need, which in some cases will be daily contact;
 - (f) Communicate regularly with the appropriate health and custodial personnel to ensure the prisoners ongoing needs are identified and appropriately managed;
 - (g) Make secure forensic mental health beds available as soon as possible and not place prisoners as a lower priority than non prisoners on the basis of their incarceration;
 - (h) Advise the Department of Corrections as to the availability of appropriate secure beds within the health system at least weekly;
 - (i) Ensure waitlisted prisoners with impending release dates are referred to the appropriate mental health service for ongoing assessment and treatment prior to release.

6 Assessment Process under the Mental Health (Compulsory Assessment and Treatment) Act 1992

- 6.1 Corrections will not initiate an assessment process under the Mental Health (Compulsory Assessment and Treatment) Act 1992 without first consulting with the Regional Forensic Psychiatry Service to ascertain the availability of an appropriate hospital bed.
- 6.2 The Regional Forensic Psychiatric Service will provide advice as to the initiation of the process or not to the Department of Corrections in writing.
- 6.3 Regional agreements under 1.4 of this MoU should clearly reflect the processes described in s45 and s46 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- 6.4 Applications for assessment must be in writing and be accompanied by a medical certificate given by a medical practitioner who has examined the prisoner within the preceding three days.
- 6.5 On receipt of an application for the assessment of a prisoner, the Director of Area Mental Health Services must arrange for the prisoner to undergo an assessment examination.
- 6.6 This assessment examination must take place either in the institution within 48 hours of the application being received or, if that is not practicable, in a hospital within 72 hours of receipt of the application. (See section 45(4)(a) of the MHA).

7. Dispute Resolution

- 7.1 Regional agreements under 1.4 of the MoU must describe a process by which any dispute regarding either a waitlisted prisoner or a prisoner who the Department of Corrections believes requires urgent mental health inpatient level of care is addressed.
- 7.2 Regional Corrections staff will escalate the matter to Prison Services national office if the matter is not able to be resolved locally. Corrections national office will contact the Population Health Deputy Director-General of the Ministry of Health outlining the concerns and steps taken to address the issue to date.
- 7.3 The Population Health Deputy Director-General will request a briefing from the clinical director of the Regional Forensic Psychiatry Service, and will attempt to resolve the dispute with Prison Services national office.
- 7.4 If the situation is still unresolved then the Population Health Directorate and the Department of Corrections will provide briefings to their respective Ministers and suggest a joint meeting of the two Ministers and their advisors to resolve the dispute.

8. Media

- 8.1 Regional agreements under 1.4 of this MoU must describe a process of regional consultation between the Department of Corrections and Regional Forensic Psychiatry Services before providing to the media information or comment on forensic mental health services for prisoners. Corrections staff are required to first consult the Department's Head Office Communications Unit in all instances.

- 8.2 If the matter is of national significance, the Regional Forensic Psychiatric Service will inform the Ministry of Health before providing to the media information or comment on forensic mental health services for prisoners.
- 8.3 If any party is concerned about any matter relating to forensic mental health services for prisoners, they will:
- (a) Raise these concerns through our appropriate internal channels, rather than through the media; and
 - (b) Ensure these concerns are notified to our relationship managers as soon as reasonably practicable so that the dispute resolution process can be utilised.
- 8.4 The contact people for all such matters involving the media will be the Manager, Communication of the Department of Corrections, the Clinical Director of the Regional Forensics Psychiatry Service, and the Manager, Communications of the Ministry of Health.

9. Amendment

- 9.1 The parties to an agreement or protocol of the type referred to in this MoU may, at any time, vary or amend the MoU by mutual agreement in writing.
- 9.2 This MoU will be reviewed in 12 months time.

10. Sign off

Signed by _____

Position _____

On behalf of the Department of Corrections

Dated _____

Signed by _____

Position _____

On behalf of the Ministry of Health

Dated _____

