

Prison Health and Public Health: The integration of Prison Health Services

Report from a conference

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Foreword

In April 2004 representatives from the health services of England and Wales, France, Norway and New South Wales in Australia met in London to discuss the responsibilities which each had for healthcare in prison. These four jurisdictions had been invited to attend because they had one shared characteristic. All those who were present had responsibilities at senior level for the delivery of health care in prisons. Yet they were employed, not by the prison administrations, but by the ministries responsible for health. In all four jurisdictions health care in prisons had previously been a responsibility of the prison authorities, as it remains in most countries, but at some point that responsibility had been transferred to the health ministry. The transfer had taken place at different times. In the case of England and Wales the transfer was still in the process of implementation. In the case of Norway prison health had been the responsibility of the national health service since 1988.

The representatives from the four countries met to consider how this process of change had been implemented, to learn from each other, to contribute to the knowledge base on how to integrate prison and public health, to discuss what benefits integration can bring both to prison systems and to society, and what difficulties can be expected. Representatives from the World Health Organisation Regional Office for Europe also attended.

The participants presented papers about their national experience and discussed this under the following headings:

- What was the policy environment which led to the transfer of prison health to the public health sector?
- What were the main elements of the process of transfer?
- What were the obstacles to successful implementation of the transfer?

- How can the outcomes now be evaluated?
- What advice can be given to other countries who are thinking of making a similar transfer?

This report summarises these discussions and also makes use of additional material supplied by the participants. The translations from French were made by ICPS. We hope that the report will be of practical interest, especially in those countries where thought is being given to the transfer of responsibility for prison health care and policy directly to the Ministry of Health, as well as to all those concerned with health and health services in prisons. It may encourage readers to consider the need for closer integration between prison and public health services.

ICPS is grateful to all those who attended the seminar and wishes to record a special word of thanks to John Boyington, Head of Prison Health, Department of Health England and Wales, and his staff for their support in arranging the seminar. I am very grateful to Helen Fair, Jim Haines, Anton Shelupanov and Vivien Stern of ICPS for their work in preparing the seminar and in compiling this report.

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August 2004

Summary

The seminar considered the experiences of four different jurisdictions where responsibility for prison health services had moved to the public health service.

The reasons for integrating prison health with the public health service were complex but, in all four countries, concerns on the part of medical organisations about both the quality of care for prisoners and the role of medical staff working in prisons were influential in leading to consideration of policy change. The high number of mentally ill people in prison and the defects in their care were also important factors.

Implementing the transfer can be a complex process. Issues of conflicts between the different health and prison cultures, the affiliation of prison healthcare staff to health or custodial professional associations, ethics and data sharing all have to be resolved. In three of the countries the transfer was accompanied by a substantial injection of new resources.

However, the gains can be great. Evaluations that have been carried out indicate that the standard of care provided to prisoners has improved in all four countries. National health policy has greater awareness of the specific health needs of prisoners. Recruitment and quality of staffing has improved. Links with health services in the community have been strengthened.

Future developments might include more involvement of public health services in the criminal justice area, leading to the possibility that more people might be diverted from prison to a health service setting. Evaluation and analysis of the health services in prison should continue to be a priority.

The experience of the four jurisdictions and the knowledge they have gained about the experience of transferring prison health care to the public health service could be more widely disseminated to encourage other countries to follow the same path.

Introduction

International experience increasingly demonstrates the importance of health in the prison setting. Health is central to many aspects of prison life and prison management, particularly since many prisoners and detainees suffer from poor health as a result of personal circumstances, lifestyle or the environment from which they come. Prisons can be very unhealthy places for prisoners to live and for staff to work. In prisons there are concentrations of people with problems that are fundamentally health issues, such as alcohol abuse, drug addiction and risky behaviour that can lead to the transmission of fatal diseases. Many mentally ill people who should be in the care of civilian health authorities are instead in prison. Suicide and self-harm rates in the prisons of some countries are very high and violence can be a daily occurrence. At the same time, prisons can provide an opportunity to deal with the accumulated health problems of some prisoners.

The provision of health care in prisons also raises human rights questions and can on occasion put considerable pressure on medical personnel to retain their professional independence in the face of the institutional values of the prison. Recent cases of the European Court of Human Rights show that inadequate health responses can lead to a violation of the European Convention on Human Rights. Mark Keenan¹ was a paranoid schizophrenic who killed himself in the segregation unit of Exeter prison in England. He had been placed there after having been certified fit for punishment by the prison doctor. In his case the Court found the UK to be in violation of Article 3 of the Convention, which prohibits inhuman and degrading treatment. Similar cases in France were that of Jean Mouisel,² a prisoner with cancer who was offered inadequate medical treatment

1 Case of Keenan v. The United Kingdom. Application number 27229/95

2 Case of Mouisel v. France. Application number 67263/01

and was handcuffed to a hospital bed, and Albert Henaf,³ a 75- year old sentenced to 6 months imprisonment, who had a psychological disorder and was handcuffed on the way to prison and to his bed. The UK was also found to be in breach of Article 3 over its failure to provide adequate medical treatment to Judith McGlinchey,⁴ a heroin addict who died in prison whilst suffering withdrawal systems.

In common with all other human beings, prisoners are entitled to “the highest attainable standard of physical and mental health” (International Covenant on Economic, Social and Cultural Rights, Article 12). Yet prison health care often fails to reach these standards. The reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)⁵ on visits to prisons in the 45 member states of the Council of Europe have highlighted serious deficiencies in some states.

Prison health has a wider significance than the care of individual people who are detained, important though that is. There is a clear public health interest in good prison health care linked closely to the national health service. The vast majority of prisoners will one day return to civil society, often to the communities from which they have come.

3 Case of Henaf v. France. Application number 65436/01

4 Case of McGlinchey and others v. The United Kingdom. Application number 50390/99

5 The CPT was established under the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and visits places of detention (e.g. prisons and juvenile detention centres, police stations, holding centres for immigration detainees and psychiatric hospitals), to see how persons deprived of their liberty are treated and, if necessary, to recommend improvements to States. One member may be elected by the Committee of Ministers of the Council of Europe in respect of each State which has ratified the treaty. Visits are carried out by delegations, usually of two or more CPT members, accompanied by members of the Committee’s Secretariat and, if necessary, by experts and interpreters. The member elected in respect of the country being visited does not join the delegation.

Some are in prison for very short periods. When they are released, it is important for the good of society that they do so in good health, rather than needing more support from the public health services, or bringing infectious diseases with them. Continuity of care between the prison and the community is a public health imperative. Many other people go into and come out of prison on a daily basis – staff, lawyers, officials and other visitors – and prisons cannot be seen as separate health sites from other institutions in society.

Therefore both the World Health Organisation and the Council of Europe have strongly recommended that closer links be made between prison and public healthcare. The Moscow Declaration on Prison Health as a part of Public Health (October 2003)⁶ noted,

Member governments are recommended to develop close working links between the Ministry of Health and the ministry responsible for the penitentiary system so as to ensure high standards of treatment for detainees, protection for personnel, joint training of professionals in modern standards of disease control, high levels of professionalism amongst penitentiary medical personnel, continuity of treatment between the penitentiary and outside society, and unification of statistics.

The Council of Europe⁷ has recommended that,

The role of the ministry responsible for health should be strengthened in the domain of quality assessment of hygiene, health care and organisation of health services in custody, in accordance with national legislation. A clear division of responsibilities and authority should be established between the ministry responsible for health or other competent ministries, which should co-operate in implementing an integrated health policy in prison.

6 WHO Europe, 2003, Prison Health as part of Public Health, WHO, Copenhagen

7 Recommendation No. R (98) 7 of the Committee of Ministers to member states concerning the ethical and organisational aspects of health care in prison

The UN Basic Principles for the Treatment of Prisoners indicate how the entitlement of prisoners to the highest attainable standard of health care should be delivered,

Principle 9

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

There are a number of ways of guaranteeing that prisoners have this access. One is by ensuring that prison administered health services have links that are as close as possible with public health. A number of countries are moving towards the idea of a closer relationship between the prison health service and public health. Many prison and public health reformers argue, however, that it is not sufficient to have a close relationship. They have maintained that prison health should be part of the general health services of the country rather than a specialist service under the government ministry responsible for prisons. France in 1994 and England and Wales in 2000 decided on total integration. Norway took a similar step in 1988 and prison medicine in New South Wales in Australia has been part of the public health system for some years with the basis set out in legislation (the Health Services Act 1997 and the Crimes (Administration of Sentences Act) 1999).

In the following sections of this short report we look at the experience of these four jurisdictions, draw out some lessons from their experience and suggest areas for future collaboration.

The four jurisdictions – background information

Australia – New South Wales

- Australia has 23,555 prisoners.⁸ Imprisonment is a State and Territory responsibility and New South Wales has the highest number of prisoners, 8,881.
- The integration of the prison health service into the public service happened incrementally.
- A Royal Commission, known after its chairman as the Nagle Commission, was set up in New South Wales following a series of disturbances in New South Wales prisons. The Commission reported in 1978⁹ and set out the principle that prisoners were entitled to adequate health care. At that time prison health care was already a responsibility of the Minister of Health.
- In 1991 the Chairman of the Board of the Corrections Health Service was appointed and in 1997 the arrangements were consolidated under the Health Services Act (1997) and put on a statutory footing.
- On 1 July 2004 the service was re-titled Justice Health Service to take account of its responsibilities for health in juvenile justice centres and its role in court diversion and pre and post release services. The service now has three branches: criminal justice, drug and alcohol services and mental health.
- The service provides health care to the 31 prisons in New South Wales and also basic health services such as methadone maintenance

8 At 30 June 2003. From Australian Bureau of Statistics <www.abs.gov.au>

9 Report of the Royal Commission into New South Wales Prisons, 1978, Government Printer, Sydney

to the periodic detention centres where convicted persons are sent to undertake community work. The service also works in some police cells and some courts.

- The service operates by means of a statutory memorandum of understanding with the Department of Corrective Services.

France

- France has almost 57,000 prisoners.¹⁰
- There are only 45,600 prison places available, with overcrowding running at 200% in some prisons.¹¹
- Under legislation of 1994 prison health came under the General Health Directorate for public health issues in the Ministry of Health.
- Health care in each prison was provided on the basis of an agreed protocol with the nearest public hospital.
- The hospitals set up consultation and health care units (UCSAs) in each prison. They are responsible for all health services to prisoners, including medical examination on admission into prison, nursing and distribution of medicines, screening for communicable diseases, dental care, health education, specialist medical care and 24 hour health cover.
- The UCSA also organises continuity of medical care on release from prison.

10 Figure for Metropolitan France only. Figure for Metropolitan France plus overseas territories is 61,032. Figures taken from French Ministry of Justice's *Statistique Mensuelle*, 1 March 2004.

11 Figure for Metropolitan France only. Figure for Metropolitan France plus overseas territories is 48,437. Figures taken from French Ministry of Justice's *Statistique Mensuelle*, 1 March 2004

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- If the local hospital cannot provide the psychiatric service a separate protocol is drawn up with another hospital.
- In 21 prisons holding 10,000 prisoners the private sector provides all services except management, surveillance and welfare. Until 2001 the prisoners in these prisons received their health care from private medical providers. In that year they were brought into the public sector prison health care scheme.
- About 120 prisoners commit suicide in French prisons annually. This is a rate of 228 per 100,000.

Norway

- Norway has 3,000 prisoners in 42 establishments, the smallest with 12-14 prisoners and the largest with 360. 32% of prisoners are held in open prisons.
- 28% of prisoners are incarcerated for drugs-related offences, 6% for sexual offences and 23% for violent offences including murder.¹²
- Norway favours the 'import' model for providing services to prisoners. For example, education and library services are provided by the local authorities and in 1988 healthcare provision was similarly decentralised.
- Healthcare in Norway operates under a three tier system: the central government level; the regional level with 5 regions with responsibility for hospitals and specialist services and 432 municipal authorities to whom responsibility is decentralised. This arrangement was consolidated by the 1994 Health Care Act.
- 42 of these municipalities have a prison under their jurisdiction and are therefore responsible for providing healthcare to it.

12. Statistics provided personally at the conference

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- General practitioners work in groups of 2-6 with help from auxiliaries and must give 7 hours a week to a public health setting such as a nursing home, a prison or accident and emergency unit.
- Healthcare is not available 24 hours a day in the prisons, and when the medical unit in the prison is closed, treatment can be provided at the local emergency unit.

UK – England & Wales

- The United Kingdom has three separate prison services: England and Wales, Scotland and Northern Ireland. There are over 83,000 people in prison in the UK.
- England and Wales has over 75,000 prisoners.¹³
- 90% of these prisoners have a mental health or substance abuse problem, or both. 80% smoke. 1.2% of women and 0.3% of men are HIV positive. 24% are injecting drug users and of these 20% have hepatitis B and 30% hepatitis C. There are about 100 suicides a year and 50,000 drug detoxifications are carried out each year.
- In 1997 a joint working group of the prison administration and the National Health Service Executive was established to look at the state of prison health care.
- Following a report from the group a formal partnership was established which aimed to bring health care standards in prison up to the level of the community.
- In 2002 it was decided that responsibility and the budget for prison health care should be transferred to the National Health Service.
- In 2003 the budget moved from the Prison Service to the Department of Health.

13 <http://www.hmprisonservice.gov.uk/resourcecentre/publicationsdocuments/>

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- In 2004 primary health care trusts took over responsibility for delivering health care to some prisons and the handover should be complete by 2006.
- Each prison has a health steering group which is responsible for delivering the local partnership between the prison and the health care provider.

The policy environment that led to change

It is not easy to disentangle the complex mix of pressures that led to policy change but it is clear that in the four participant countries the impetus for change did not come primarily from the prison administrations or medical personnel working in prison systems but from public health professionals both in medical associations and in government bodies. These public health experts expressed concern about both the quality of care and the role of medical personnel in a prison environment. Of particular importance was concern about the numbers of mentally ill people in prison and the treatment they were receiving. In some places a specific scandal generated a public debate which also played a part in raising awareness of the need for change.

Views from the medical profession were a feature in both Australia and the United Kingdom. The Australian Medical Association had recommended that prison health care should be provided independently of the prison authorities. The British Medical Association campaigned for many years for better prison health care, raising questions about the use of psychotropic drugs and deaths in custody. Influential reports also played a part. In England and Wales the Chief Inspector of Prisons published a paper in 1996 arguing that the National Health Service should take over prison health care. In France a report from the Haut Comité de la Santé Publique in 1993 highlighted problems with prison health care.

In Norway the change was part of a wider prison reform effort supported by public health interests and based on a health philosophy summed up as follows:

Our national health policy is based on the belief that everyone living in Norway has a right to adequate health care. This is a right of everyone regardless of one's socio-economic status, beliefs, race, age, sex, or being imprisoned.

Problems in Norwegian prisons with mentally ill prisoners led to a number of reports that made proposals for change in the arrangements for delivery of health care to prisoners. The journal of the Norwegian Medical Association pointed out deficiencies and a scandal in an institution which was later closed highlighted the need for attention. The trade union representing the prison officers in Norway was also very active in pointing out defects, especially in the care of the mentally ill.

How the change was achieved

Transferring responsibility for prison health care from the control of the prison system to the control of the health ministry is a complex process which is likely to affect a number of different interests and to bring together two groups with a very different professional view of the world. Existing prison health personnel are liable to feel threatened and to suspect they will be judged unfavourably by their colleagues who come in from outside. Other prison staff may resent working alongside colleagues who seem to be outside the chain of command and who are responsible to another body with different values. The public health service may feel it has enough to do and to question why it should take on difficult work with prisoners. Certainly, all four jurisdictions reported the existence of such tensions to varying degrees. A research study carried out in 2000 on the health care changes in France noted that:

The prison guards saw the arrival of external medical staff as an intrusion. Conflicts occurred in the early stages mainly over the independent medical status of the new practitioners and the identification of the health care staff with humanity and the guards with repression. Medical confidentiality was at the heart of a great deal of the conflict between health care staff and guards. Health care staff were unsure of their role in the maintenance of order and pursuit of the prison objectives.¹⁴

Timescale

A lengthy programme of gradual transition is one way of approaching the change. In England and Wales the transition started with a joint

14 Coyle, A. and Stern, V. 'Captive Populations: Prison health care' in *Accessing health care: Responding to diversity* (2004) Healy, Judith and McKee, Martin (eds.) Oxford University Press: New York, pp 109 – 125.

prison/health service working group in 1997 and will not be completed until the last group of primary health care trusts takes over in all the prisons in 2006. Budgets and staff are being transferred gradually over this period. To support the change from 2003 to 2006 a major communications programme has been developed to bridge the gap between two very different groups (prison healthcare staff and local primary care trust staff). The gaps include different systems for their work, with different protocols and competing priorities. The prison system is centralised whilst the health service is devolved to local areas. The prisons are more concerned with security. The national health service organisations have concerns about public health priorities and issues such as waiting times for patients.

In France too the transfer has proceeded in stages. The main transition took place in 1994. Prisons served by private contractors became part of the scheme in 2001 and developments are continuing to set up in-patient units in regional hospitals and to make special arrangements for mentally ill prisoners.

Hospital care

A number of logistical and practical problems are common when providing care to people who have lost their liberty. The most difficult area is when prisoners need to go to hospital for in-patient treatment. Some countries deal with this problem by establishing fully equipped prison hospitals so that prisoners can be treated within the prison environment. New South Wales has a prison hospital, with three-quarters of the beds used for psychiatric patients and one-quarter for low dependency post-surgery cases. When prison health care is to be provided by the public health service it will be expected that prisoners should receive in-patient treatment in public hospitals. When they present any level of security risk, security has to be provided at the civilian hospital where they are sent. This can lead to contentious practices such as handcuffing or shackling prisoners to their hospital beds, practices deemed to be 'inhuman and degrading' by the European

Committee for the Prevention of Torture (CPT). It can also create demands for prison staff to escort the sick prisoner to hospital and to remain there guarding the prisoner.

In France the integration of prison health into the hospital service has led to extensive plans for change in this area. Eight secure hospitals for prisoners needing intensive care will be established within teaching hospitals. In these units prisoners will get the same level of care as is provided in the rest of the hospital and prison staff will provide external security. The discussions on establishing these units have been lengthy and complex because of the difficulty of integrating public health functions and culture with prison functions and culture. New South Wales has one secure ward in a health service hospital in Sydney.

Resources

Resources are also an important consideration. Once the standards applied in the public health system are applied in prison health, it may well become clear that prison health provision has been dramatically underfunded. In France, England and Wales and Norway the transfer was accompanied by a substantial increase in the budget for prison health care. In England and Wales revenue increased by 30% and between 2003 and 2006 an extra £60m will be injected. In Norway the transfer increased per capita expenditure by 100%.

Personnel

The status of personnel may present some difficult issues. Where prison health care staff work for the prison administration they are likely to belong to trade unions representing custodial staff. This may be felt to be quite inappropriate for health staff in prison working for the health service. An important part of the transition when existing staff are to be transferred from prison to health ministry control is to integrate them into professional networks of counterparts and health service training structures.

In these early days of formal training in prison medicine, curricula will vary widely, but an essential element in any programme should be to guard against loss of empathy with the patients in an environment where callousness can so easily creep in. Also essential is full support, from academic medicine, health services, and prison services, of carefully thought-out programmes, so that they can be properly assessed.¹⁵

Ethical issues

The special ethical dilemmas facing health personnel in custodial settings need to be identified and taken into account. The patients are also prisoners. For example, what is to be done when prison doctors are asked to certify that individual prisoners are fit for work or for punishment? In England and Wales in 2002 a policy paper on ethical issues was produced dealing with questions such as restraining violent prisoners and responding to hunger strikes. Questions may also arise about the transfer of data. Issues of medical confidentiality may need to be dealt with in the context of health personnel working in prisons who are not employees of the prison administration. In New South Wales the prison authorities can have access to prisoners' medical records with the informed consent of the prisoner. Similarly, transfer of health information between states or territories requires the authorisation of the prisoner. However, mental health records may be released to health authorities without the prisoner's consent. The prisoner has to give formal consent to health service provision, under the same conditions that apply in the community. Health care providers have an option to enforce medications under conditions that are monitored by bodies such as the Mental Health Review Tribunal.

15 Editorial. Correction of attitudes to prison medicine. *Lancet* 1998; 351: 1371.

Decentralisation

The transfer to the public health service may also entail a decentralisation from a national to a local service. This has been the case in Norway where the regional level of health administration negotiates with the municipalities to ensure adequate services. Local solutions have been found but this has resulted in significant differences between the way health services are provided in different prisons. Local committees in which the health authority meets the local doctors to resolve problems have been established in Norway as one way of dealing with this problem.

The benefits of change

The arguments for integration

Advocates making the case for the integration of prison and public health services have deployed a number of arguments, including the following:

- Medical staff who are not in the employ of the prison authorities and who owe their allegiance to the public health service will find it easier to make independent judgements and always put the needs of the patient before institutional requirements.
- Independent medical staff will be able to argue strongly for measures to be taken that improve public health such as harm reduction measures, even when these cause difficulty within the environment of a prison.
- Prisoners are more likely to trust medical staff who are employed by the health authorities rather than the prison authorities.
- Prisons are places of considerable traffic with a large inflow and outflow of prisoners, visitors and staff. Therefore the infections of the prison soon become the infections of the wider community and a co-ordinated response is more likely to be effective.
- Continuity of care is more likely to exist if the same organisation has responsibility both inside and outside the prison walls.
- Quality of staff is likely to be higher when prison health is a mainstream discipline and there are wider opportunities for advanced training and research.

Policy gains

Experience from the four participant countries suggests that these and other benefits can come from integration of prison and public health services. For example, the expressed French view is that:

The law of 18th January which set up a consultation and out-patient service (UCSA) in each prison to take responsibility for primary (general) health care has been a real revolution.

First of all there are definite policy gains. Whereas prison health tends to take a reactive approach, dealing with prisoners who present with ailments, the transfer to public health can lead to more analysis of the health needs of the whole prison population and the introduction of measures to meet the identified needs. New South Wales carried out Inmate Health Surveys in 1996 and 2001 to guide their provision.

There is a major difference between contracting with an outside provider for health care services and integrating prison health into the public health service. A contractor can be expected to provide a good service to individuals. But the involvement of the public health service can lead to the involvement of health professionals in policy matters such as the effects on prisoners' mental health of punishment and isolation, the importance of diet and exercise, or the ill-effects of overcrowding. In New South Wales the public health service has developed the argument and convinced prison staff colleagues that a good health service in prisons can contribute to an improvement in overall management and good order.

The integration with public health can also affect prisoners' status. In France for instance the new system enables prisoners to affiliate to the social security system under the Ministry of Health. The new arrangements can bring prison health experts into wider aspects of the work of the Ministry of Health. In France a new national institute for preventive medicine and health education is developing health education programmes for the whole population and some of its staff are prison health specialists. In 1998 the Public Health Association of

Australia convened a national conference on prison health. Outcomes of that conference include the inclusion of prisoners in the national hepatitis C strategy and the national HIV/AIDS strategy.

Better healthcare

Being part of the public health services can bring improvements in delivery of healthcare to prisoners. It can give easier access to community services such as community mental health or dental services. It can lead to speeding up the provision of psychiatric reports and the time taken to transfer a prisoner to an outside hospital. Detoxification facilities can be brought up to the standards the staff are used to outside prison. It gives the opportunity for keeping track of the patient, both in prison and outside. Once prisoners become the responsibility of the ministry for health they become eligible for attending publicly available training programmes by health professionals on subjects such as hygiene, risky behaviour and protection from infection. In England and Wales the transfer process led to the identification of prisons where the quality of provision was very low. Concentrated effort produced an improvement with 17 prisons moving out of the bottom category between 1999 and 2003.

Psychiatric problems are found disproportionately in prisons worldwide and the treatment of mentally ill prisoners is often a source of adverse comment from human rights bodies. In France the transfer of prison health to public health has highlighted the need for a reform of psychiatric provision. In 1997 20% of men and 30% of women in French prisons had mental health problems. A survey was set up to carry out further research into this and to look at the short and long term effects of imprisonment on mental health. An analysis of mental health provision showed that the level of resources was inadequate and they were unevenly distributed. Statutory hospitalisations (sectioning) have increased 15-fold since 1994 and the problems of holding such prisoners in general hospitals have led to lower levels of care. A plan to improve mental health services in prisons in France has been developed

based on out-patient services and providing a range of interventions from initial assessment to co-ordination with prison aftercare services.

Better for staff

Recruiting properly trained personnel to work in prison healthcare is often difficult. In integrated prison/public health services it can be easier to attract staff. New South Wales has found this to be the case. Staff see the advantages of more career possibilities, the opportunity to carry out research and the opportunity to teach specialists and generalists about prison health. In France prison staff and health staff have attended joint training programmes on relevant matters such as prisoner suicides. In New South Wales prison-based nursing has seen substantial development as a sub-speciality of nursing. The New South Wales College of Nursing has developed a graduate diploma in Correctional Nursing. The University of Sydney graduate medical programme has an agreement with the Justice Health Service to enable students to undertake training placements in prisons.

Measuring change

All the participant countries have developed various ways of measuring progress, charting improvements and analysing deficiencies in order to rectify them. Greater coverage of hepatitis B vaccination and higher birth weight of babies born to imprisoned mothers were two measures that had been used. Recording the time that prisoners waited before they received mental health treatment or dental treatment were also used as performance measures.

Surveys have also been used. One carried out in Norway in 2001 showed that prisoners were well-informed about the health service in prison and received good primary care but there was a lack of capacity to meet mental health needs. These findings were confirmed by a later survey by the Institute of Applied Social Science which reviewed the provision of mental health services to prisoners needing them. This found that only 50% of prisoners wanting help received it. In New South Wales, a pilot programme is developing a measure of the time it takes to arrange for the community health services to sign on released prisoners.

In France a joint evaluation of provision was carried out by the Inspectorates of Social Services and Judicial Services in 2001. The evaluation found some unmet needs and in order to implement their recommendations finance has been provided for more dental care, specialist consultations and psychiatric services, and more effort has been put into dealing with addiction and preventing transmission of HIV and hepatitis.

The objective of the French reform was 'to guarantee to prisoners a quality and continuity of healthcare equivalent to those which are available to the general population.' Release from prison is a time of key importance for public health, when follow-up is important in order to ensure that treatment started in prison is continued and that

arrangements for access to medical services are set up. Evaluations show that so far in France the changes have not led to the expected improved medical and social supervision on release. Also in France co-ordination of the specialists in general and psychiatric medicine in the care plan for the individual prisoner is not yet satisfactory and at night prisoners do not have access to a doctor whereas the general population has such access. Problems with inpatient care continue because of a shortage of escort staff, who come from the prison and police service. Hospital consultations and inpatient treatment are often cancelled at the last minute. Norway also faces a problem of taking prisoners to hospital because of the pressure it places on staff resources.

Norway accepts that prison mental health services are still not adequate and long waits occur for outpatient and inpatient services. The most modern methods of dealing with drug withdrawal have not been introduced uniformly.

In New South Wales increasing efforts are being made to improve continuity between prison health care and the health service outside prison through better discharge planning. At the simplest level, a discharge summary is prepared and provided to the former prisoner's health carer, with the prisoner's consent. A programme is being developed to enable health staff working in the prisons to follow up prisoners with an ongoing mental health or drug addiction problem. One of the aims of the programme is to break down the resistance of community-based health services to engage with former prisoners.

Concluding thoughts

The conclusions to be drawn from this brief comparison of the experience of the four countries must be tentative. However much emerged that was overwhelmingly positive. A neglected and often secret part of health provision has been brought out of the shadows and into the mainstream of health policy. Access to good health care in the four countries is part of citizenship. Through the integration of prison and public health prisoners have been recognised as temporarily incarcerated citizens. Their stay in prison should not adversely affect their access to care of a standard they would receive in the community. Health policies for the population at large have also been applied to the prisons. Working in prisons has become a good career option for well-qualified professionals. Monitoring and evaluation have shown the weaknesses and plans have been developed to overcome them.

In the future there is perhaps scope for even greater involvement of public health services in the criminal justice area, working, as is done in New South Wales, in courts and police stations, to divert people from placement in a prison setting when a health setting would be appropriate and humane. Evaluation of the integrated health services to analyse and assess the effects on prisoners' health should be a priority. Wide dissemination of the findings should be undertaken so that other prison and public health services can see the advantages of bringing prison health into public health. The World Health Organisation and the Council of Europe should be informed of the progress of integrated prison/public health services so that they can bring the information to the attention of other states.

List of delegates

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Prison Health and Public Health: The integration of Prison Health Services

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