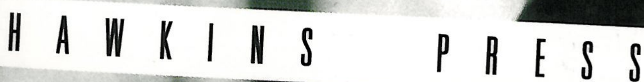
Editors
Sean O'Toole & Simon Eyland

CORRECTIONS CRIMINOLOGY



Published in Sydney by:
Hawkins Press
An imprint of The Federation Press
PO Box 45, Annandale, NSW, 2038
71 John St, Leichhardt, NSW, 2040
Ph (02) 9552 2200 Fax (02) 9552 1681
E-mail: info@federationpress.com.au
Website: http://www.federationpress.com.au

National Library of Australia
Cataloguing-in-Publication entry

Corrections criminology.
Bibliography.
Includes index.
ISBN 1 87606 717 9

1. Corrections – Australia. I. O'Toole, Sean II. Eyland Simon.

365.994

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Typeset by The Federation Press, Leichhardt, NSW.
Printed by Southwood Press Pty Ltd, Marrickville, NSW.

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Prisoner health

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Any description of the health of prisoners needs to commence with the reiteration of the principle that a when a court of law sentences someone to imprisonment, "deprivation of liberty" should be the only punishment. Regrettably, in Australia at the turn of a new century, too many citizens are incarcerated because of the consequences of illness.

In reality the "punishment" is only the beginning of a complex and punitive criminal justice system – prisoners, their families and their partners experience a number of "losses". There are levels of punishment – loss of privacy and loss of intimacy are just two that directly impact on the health of Australian prisoners. Regrettably, we confine our prisoners in conditions of physical squalor and overcrowding with the consequent health risks. Australian prisoners lose their Medicare entitlement. While this merely shifts the responsibility of primary health care onto the States and Territories, it significantly reduces the option of "second opinions" that the prisoner may request (as this now needs to be paid for by the prisoner or their family). These health risks and consequent health outcomes are readily transferred from the prison environment back to the outside community.

Prison health services in Australia

There is an absence of uniform standards for the provision of health services to Australian prisoners. The federal Minister of Justice and Customs has a reporting role to Parliament on the state of the nation's prisons. However, neither that Ministry, nor the Commonwealth Ministry of Health and Ageing have identified a mechanism for monitoring State and Territory performance in custodial or prisoner health matters.

This leaves the States and Territories to develop systems in isolation from each other. Health services to prisoners in NSW are provided by the health department (through the Justice Health), in Queensland and Western Australia the custodial authority funds health services, in South Australia, the

Australian Capital Territory and Tasmania there are contractual arrangements between the health department and a health service provider, while in the Northern Territory and Victoria, health services are privatised. The Commonwealth does have responsibility for Immigration Detention Centres, but here too the services have been contracted out, so the federal government maintains its distance. Paradoxically, the area of Commonwealth interest for prisoner health remains the fate of Australians incarcerated in overseas prisons, where consular responsibility cannot be delegated. However, prisoner health is not an area of demonstrated concern.

The prison environment in Australia – implications for health

Because of the eight different jurisdictions operating custodial facilities there is no single characteristic of the Australian custodial system. Prisons range from less than 50 beds to over 1000; some have been operating continuously since the 19th century, some have been built recently, but have not yet been commissioned. All Australian facilities are single gender (or where there are males and females in close proximity, always segregated). All Australian jurisdictions separate adult from juvenile detainees in full-time custody. However, while in police custody, males and females, young and old might be held in the same facility for a number of days.

Prisoners are moved frequently between prison and court, between prisons themselves, and between the community and prison. This makes continuity of health services, and contact with family members difficult. In June 2003, there were 123 custodial institutions in Australia. With an official capacity of 22,000, the occupancy rate for Australian prisons was 106 per cent! Hardly conducive to privacy, intimacy and respect of the individual's rights, but conducive to the transmission of airborne, droplet spread and other infections.

Aboriginal health – the health priority

The proportion of prisoners who were Aboriginal and/or Torres Strait Islander rose from 14 per cent in 1992 to 20 per cent in 2002. In 1991 the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) handed down its recommendations. RCIADIC made 29 recommendations specifically directed to the principle of imprisonment as a last resort. Since the handing down of the report, however, the level of over-representation of Aboriginal and Torres Strait Islander people in prison has increased unabated, from year to year.

Aboriginal and Torres Strait Islander citizens make up less than 2 per cent of the Australian population. Yet 20 per cent of the Australian prisoner population are identified as Aboriginal and/or Torres Strait Islander. The Australian Bureau of Statistics reported this as an incarceration rate of 1,806 prisoners per 100,000 adult Indigenous population – 16 times higher than for non-Indigenous Australians. This is the highest incarceration rate for Indigenous citizens of all Organisation of Economic Co-operation and Development

(OECD)[1] countries. The highest Indigenous incarceration rate is in Western Australia (2,414 per 100,000 adult Indigenous population); however, there has been a 20 per cent reduction in the Indigenous incarceration rate in that State between 2001 and 2002. Indigenous juveniles account for 42 per cent of juvenile detainees in Australia (Human Rights and Equal Opportunity Commission, 2002).

What is the socio-economic background of Australian prisoners?

The social and physical environment of prison has a great effect on health behaviours. Given that a person's perceived status in the world is dependent on education, income, employment and life satisfaction, it is clear that imprisonment strips each component away. Poor prior education, low income, meagre employment and poor self-esteem typify the prisoner entering the prison gate; and ever more so at the point of exit. Sexual abuse, physical maltreatment, emotional maltreatment, abandonment, and suicide attempts by significant others are common life experiences of prisoners (Blaauw et al, 2003). When asked about previous sexual abuse, 69 per cent of female inmates and 29 per cent of male inmates reported that they been victims at least once, with 35 per cent of female and 10 per cent of males being involved in two or more such incidents (Butler and Milner 2003).

Equity is a function of fairness and social justice (not to be confused with criminal justice) and is largely beyond an individual prisoner's control. Consider issues such as the over-representation of Aboriginals and Torres Strait Islanders, perpetual unemployment and entrenched social dislocation of Australian prisoners – and one readily appreciates the fatalism common around issues of incarceration and health – sexuality being a prominent example.

Prison is an environment of power relationships, low interpersonal trust, values touched by punishment and corruption, and deeply moralistic. For example, condoms are available in prisons in New South Wales, Western Australia, the Australian Capital Territory, and Tasmania; they should be available to inmates in South Australia (but this has been effectively blocked by the prison officers union) and Queensland (where they have been withdrawn for financial reasons). Prisoners in those States have no control over the level of protection afforded them *by the Crown* should they have successfully negotiated consensual penetrative sex.

The 1996 NSW Inmate Health Survey reported that a higher proportion of male prisoners who were survivors of childhood sexual abuse reported involvement in both consensual and non-consensual sexual activity in prison,

1 Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Republic of Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, UK and USA.

compared to those with no such history. No comparable conclusions could be drawn for females, as there were too few participants (Butler, 1997).

The 2001 New South Wales Inmate Health Survey reported on a broader range of sexual health issues, including sexual identity, gender of sexual partners, age of first intercourse, the number of life-time sexual partners and the number of sexual partners in the previous 12 months. Ninety-five per cent of men and 63 per cent of females self-identified as heterosexual. Four percent of male respondents, and 30 per cent of females, identified as bisexual, with the remainder identifying as homosexual.

The Inmate Health Survey was conducted in a prison system with virtually no restrictions on access to condoms (in the male system) and dental dams (in the female system). Yet only 12 per cent of male respondents and 18 per cent of female respondents stated that they had tried to obtain either condoms or dental dams. The researchers noted the impact of sexual assault in prison – both male and female. Protection scams among prisoners do include physical abuse, coercion and sexual favours as "currency".

Little is known about sexual activity in Australian prisons. One published report from NSW stated that 25 per cent of young offenders could expect to be raped in prison. In that study, the key causes of sexual assault in prison were stated as: (1) perpetrators seeking power through sexual assault: (2) the acquiescence of prison authorities; (3) overcrowding; and (4) the prior sexual experiences of perpetrators (Heilpern, 1998). Young prisoners, particularly those serving their first custodial sentence, are also at higher risk of sexual assault. The risks also increase in maximum-security facilities. The practice of remanding all offenders in maximum-security facilities exposes young offenders to more experienced criminals who have committed more serious offences, making remand centres particularly risky.

It is worth noting that there is a spectrum of sexual activity within correctional facilities. As in the general community, a proportion of prisoners will be homosexual and may choose to participate in consensual homosexual activity while in custody. Prisoners who identify as heterosexual in the community may choose to do the same. Other prisoners may participate in sexual activity, despite preferring not to, either as a form of protection or as currency. At the end of the spectrum is the risk of sexual assault within custodial settings.

There are other special features about sexual assault in the prison setting. Commonly, there is considerable reluctance to report sexual assault as this breaks the prison code and necessitates the victim going on protection, which is often viewed as worse than keeping silent. Partly because of this, victims can be the subject of repeated assault and may go to extreme measures, such as self-harm, to gain protection.

The different Australian jurisdictions have developed different models of screening and treatment for sexually-transmitted infections. Compulsory testing for HIV was introduced in New South Wales in 1991 following the malicious stabbing of a prison officer with a syringe filled with HIV-positive blood. It was replaced by voluntary testing in 1995. Compulsory testing for HIV is practised in the Northern Territory and Queensland. All jurisdictions

would claim that testing, even if compulsory, is conducted with informed consent – such are the paradoxes of providing health care in the prison environment. All testing is carried out with pre- and post-test counselling. Screening for other sexually-transmitted and blood-borne viruses is conducted to a varying degree in the different jurisdictions. Aboriginal inmates can benefit from the Commonwealth-funded PCR screening program for *Chlamydia trachomatis*.

Access to health services

All prisoners have access to primary health services while in prison. Given the complex health problems of the prisoner population, access to services while in the outside community is often poor. It is not unusual for a new prisoner to have a backlog of dental health, mental health, drug and alcohol problems – and not unusually, sexual health problems. A measure of this deficit is that while over 40 per cent of NSW prisoners are infected with the hepatitis C virus, one-third of these people receive their first hepatitis C test while in prison. A recent report on hepatitis B immunisation among injecting drug users reported that the strongest predictor for immunisation was having been in prison (Day, 2003).

So how ill are Australia's prisoners?

The best assessment of the health of the prisoner population is, on a world scale, the New South Wales Inmate Health Survey – conducted in 1996 and repeated in 2001 (the 2001 survey was replicated with female inmates in Queensland). The results are truly amazing:

- 64 per cent of women and 40 per cent of men had been infected with hepatitis C (compared with approximately 2 per cent in the general community);
- 39 per cent of women, and 45 per cent of men had sustained a head injury so serious that there had been a loss of consciousness (no similar result is known for the general community);
- 95 per cent of women and 78 per cent of men have at least one chronic health condition – and most have more than one;
- 83 per cent of women and 78 per cent of men smoke tobacco – levels not experienced in the general community for over 40 years;
- 60 per cent of women and 37 per cent of men had been sexually abused before they had reached the age of 16 years of age.

Can prisons better reflect society? Social norms ... better health

The issue of sexuality and sexual licence is rarely discussed in the Australian prison context. Yet consider the issue of conjugal visits for prisoners in Australia. Conjugal visits are sanctioned to a limited extent in some Victorian

(Loddon, Bendigo, Yarrawonga) and one Tasmanian (Hayes) prison. This is in contrast to some western European (Spain, Portugal, and Switzerland), Middle Eastern (Iran), central/South American (Peru) and Asia (Thailand) prison systems, where conjugal visits are arranged, regardless of the security classification of the prison inmate.

In no correctional centre in Australia can male and female inmates meet. However, in some Spanish prisons, male and female inmates intermingle. While residential areas are segregated, inmates can disclose a relationship to the Governor, and qualify for "intimate visits", with prior partners or with other inmates. These arrangements are available to inmates at each stage of incarceration – remand and sentenced, maximum to minimum security. Irrespective of the stage of sentencing and classification status, inmates are eligible for three intimate visits from family or friends, per month. A fourth visit can be "earned". Homosexual relationships are tolerated, as are relationships that have been established within the prison. Prostitutes are not allowed to visit – although this is an arrangement tolerated in some South American jurisdictions. Doesn't this just reflect community standards?

Continuity of health care

Incarceration, apart from being "deprivation of liberty", is a major dislocation from the community – even if previous connections are judged dysfunctional. Health care provision in the community, and in prison, connects with great difficulty. Prisoners may have multiple health care providers in the community – some or none are the advisors on past or current health problems; some of these treatments may be complied with, others not; some may be in a functional health care provider/client relationship, others not. While this dynamic is simplified while in prison, with a single health care provider, and the capacity to supervise all treatments if necessary, the prospect of release once again brings with it the possibility of therapeutic chaos and poor compliance. No health care provider – in prison or outside – has yet overcome these seemingly insurmountable problems. The result of these failures is unnecessary reincarceration for the results of poor treatment compliance, and in the extreme, the high rate of immediate post-release mortality of drug-dependent former prisoners.

The impact of incarceration on inmates and on partners and children – the health of those left in the community

> [T]he prison indirectly produces delinquents by throwing the inmate's family into destitution. (Foucault 1977)

Lord Woolf in his report following the 1991 Stangeways (Manchester, United Kingdom) prison riots identified that domestic and employment prospects

diminished drastically through the act of incarceration. A 2001 NSW report made the following observation – 62 per cent of females and 70 per cent males reported being in a stable relationship before coming to prison. Of these, only 69 per cent of females and 65 per cent of males expected to resume that relationship post-release. (Butler and Milner, 2003)

Partners face adversities such as the stress of partner loss, witnessing the arrest and accompanying violence, the rapid change from dependence to the "absence of dependable partner", multiple contacts with the criminal justice system, separation, coercive pressures to acquit the partners debt (in and out of prison), stigma and the impending release of a partner. Australian custodial authorities have demonstrated their incapacity to support equity initiatives – judging by the response of Australian authorities, sexuality is seen either as a threat to security, good order and management, or its deprivation as a suitable and just punishment.

Conclusion

Until the basic principles of incarceration are adhered to, Australian society will perpetuate inequity – beyond health. To achieve equity for prisoners, fewer citizens should be consigned to punitive incarceration. Those who are should reside in an environment that promotes principles of health, justice, fairness, safety, and respect. Three guiding principles could enhance the status of Australian prisoners, and their families.

First, once deprived of liberty, the detainee should be offered all the benefits and responsibilities of a citizen – accordingly, sexuality should be acknowledged as a fundamental quality of human life, which is important for health, happiness, individual development and preservation of the human race. Second, the correctional environment should respect the individuals' right to privacy and intimacy as a right, not a benefit. Finally, violence, including sexual violence, must not be tolerated – neither in the community, nor in prison.

The accepted principles of harm minimisation should guide policy development and application within Australia's prisons. Good sense should not be confused with leniency. Conjugal visiting rights for all Australian prisoners, and their partners, makes good sense. All prisoners, irrespective of the stage of sentencing and the crime of which they are accused of should have contact with partners – irrespective of disclosed sexuality. Operational considerations will modify this for some prisoners, but a sympathetic approach would preserve the principle of intimacy. Health differentials between prisoners and the outside community, deleteriously affect the general health of the community. Addressing health inequalities among prisoners will provide benefits to both prisoners and the Australian community.