Models for Managing Health Services in a Multiprovider System

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Privatisation and Public Policy: A Correctional Case Study

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Introduction

Health care for prisoners in Victoria has historically been provided by the State Government Department responsible for Health. The service system involved a single provider of health care with a central concentration of health services. Services provided included a hospital and psychiatric unit at Pentridge, and a network of centrally co-ordinated service providers in each of the states outlying prison locations.

The service model recognised the advantages of the independent provision of health services into correctional environments. It addressed the critical requirement of effective co-ordination and “partnering” between Correctional Services and Health, by co-ordinating the prison health care system through a high profile inter-departmental Board - Corrections Health Board. This Board comprised senior Departmental officers and had reporting lines direct to the Ministers for Health and Corrections. From the mid 1980’s the Victorian model set the benchmark for prison health service provision in Australia.

In 1993 the Victorian Government announced a massive redevelopment program for the Victorian prison system. In summary this involved the closure of the dysfunctional and outdated Pentridge Complex in Melbourne, and the old Fairlea Womens Prison, and their replacement with new purpose built facilities (3) to be developed and provided by the private sector. Approximately half the states prison bed stock was to be replaced and privately provided. The balance of prison beds was to be provided by a new and more commercially oriented public corrections agency.

Prison health care provision was understandably a subordinate consideration in this radical prison redevelopment. Government policy was clear, however, in that each private prison was to be responsible for provision of all operational requirements including health care, and publicly operated prisons were to outsource their health care. The Department of Justice was to be the single Government purchaser of all correctional services. Consistent with previous Victorian policy though was the decision that the Health portfolio was to retain responsibility for setting prison health service standards and policy, and the critical performance monitoring role.

The challenge was then to capitalise on this opportunity for reform and to develop a quality contemporary prison health service system in this new multiprovider environment. Three private prisons each with different operators, all new to Victoria - 10 public prisons with a single public operator never previously responsible for health care. Four providers in all across 14 prisons and 2500 beds. The health care redevelopment task was unquestionably complex, but offered an unprecedented opportunity for reform.
### Table 1

**Victoria’s Multi-Provider Correctional And Health System**

**Private Operators**
- Australian Correctional Management: 600 bed prison at Sale with Central Wellington Health Service
- Corrections Corporation of Australia: 125 bed prison at Deer Park with Brimbank Community Health Centre
- Group 4: 600 bed prison at Laverton with St. Vincents Hospital

**Public Operator CORE**
- Melbourne Assessment Prison: 220 bed - reception function (health care, including Acute mental health program, to be outsourced from 1/1/99 - interim provision by the Department of Human Services
- Barwon Prison: 250 bed - health operator to be outsourced from 1/1/98
- Loddon Prison: 240 bed - health to be outsourced from 1/1/98
- Ararat Prison: 200 bed health as above
- Bendigo Prison: 100 bed as above
- Beechworth Prison: 120 bed as above
- Won Wron Prison: 150 beds as above
- Dhurringile Prison: 120 beds as above
- Langi Kal Kal Prison: 75 beds as above
- Tarrengower Prison: 50 beds as above

**Prison Closures**
- Coburg Complex: Pentridge and Metropolitan Reception Prison (MRP) including Human Services operated prison hospital and psychiatric unit
- Sale Prison
- Morwell River Prison

This brief paper will attempt to capture the major issues in the development and delivery of a new generation Victorian prison health care system. The paper will identify the critical “big” contextual issues around health service provision in correctional environments plus those pertaining to the unique conditions applying to the new Victorian Correctional system. An outline of the overall service response, solutions to some key problems and identification of some emerging issues of national application is presented.
Key Prison Health - Public Policy Considerations

1. Prisoners have special health care needs and will by virtue of their prisoner status be restricted in their choice of and access to health providers. Government must ensure that health service provision recognises these issues both for moral and practical reasons. Litigation related to prison health care is rising in Victoria and on the basis of U.S experience it could potentially become a prominent feature in prison health care. Service design and quality must be cognisant of this phenomenon.

2. Quality health care plays a critical role in the manageability of prisons - health care features not far behind food and visits as issues of importance in prisoners daily lives.

3. Alleged inadequate health care in prisons can (and does) become a public issue. It can threaten public confidence in any governments’ prison reforms. Health care in prisons needs to be both high quality and seen to be high quality. Public confidence is important also because issues such as infectious diseases in prisons can become a real and/or perceived threat to public health (eg. TB, HIV, HEPC) and the community.

4. Prisoners in Victoria (unlike other jurisdictions) have a statutory right to health care - s.47 Corrections Act 1986.

Key Policy Requirements for Health Care Provision in a Multi-provider Environment

1. That the service design framework and policy ensure that the health care arrangements operate as a system and not a disparate group of providers/services.

2. That there is effective continuity of health care for prisoners who move between private prisons, and between private and public prisons.

3. That there is an appropriate level of separation between correctional and health service provision ie. health decisions are not compromised by custodial considerations.

4. That there is a central capacity for clinical co-ordination, advice and support for satellite service providers/practitioners whether public or private.

5. That new health care arrangements must be robust and provide quality appropriate health care to prisoners at a community standard.

6. That arrangements are resource effective and there is no unnecessary service duplication.

7. That there is no inappropriate cost shifting between prisons and between publicly and privately provided prisons, and to the public health system.

8. That service standards are consistent across all the prisons, private and public and that program and eligibility rules for discretionary health programs are not variable.
Victoria’s New Prison Health Care Arrangements

The new Victorian approach to prison health care in a multi-provider environment is best understood as a multi-layered response to the service issues and policy requirements referred to above. These arrangements include:

(a) Adoption of a 3 level health care intervention continuum (Primary, Secondary and Tertiary Care) encompassing all health care needs.

(b) Design of a new service system together with rules of operation.

(c) Development and provision of service specifications for each level of health care.

(d) Prescription of standard eligibility requirements for discretionary programs to apply across every prison in key areas eg. dentistry.

(e) Design and establishment of a health service monitoring system linked to, but independent of, the DOJ monitoring system.

(f) Provision of an independent (health portfolio) expert policy advice and support function to the DOJ.

(a) The adoption of a 3 level health care model:

This model provides a convenient means of readily describing service levels across the new correctional system.

- **Primary health care** are those health services routinely provided at a local level, such as medical practitioner sessions, psychiatric consultants, nursing services, dentistry, optometry and limited access to pathology and radiology.

- **Secondary health care** are those services usually found in a community or district hospital. These services are usually subject to referral from Primary Care. Such services may include inpatient services (acute medical, surgical and accident and emergency), inpatient nursing, ambulatory care, psychiatric services not requiring involuntary admissions and specialist medical outpatient services. Secondary services may also include support and allied health services such as physiotherapy, occupational therapy and diagnostic services.

- **Tertiary health care** services are those services usually found in a major hospital or referral centre and include the highest levels of diagnostic and treatment services. These services are usually subject to referral from Primary or Secondary Care.

(b) The new service system and rules of operation:

In a nutshell it has been determined that each correctional provider private and public, will provide primary care health services within their own prisons, (including accident and emergency arrangements).

A single 20 bed secondary health care hospital facility is to be provided as a statewide (public and private) service within the privately provided Mens
Metropolitan Prison (MMP) at Laverton. This secondary care facility will also provide access to any required tertiary care level services, whether they be generic at St. Vincents Hospital (purpose designed security ward and specialist outpatients) or highly specialised such as cancer treatment at Peter McCallum Institute. Further, the secondary care prison hospital will act as the “hub of the wheel”, in the sense of providing some central clinical coordination and back up support and advice to satellite primary care clinicians in both private and public prisons around Victoria.

In addition, the MMP will also provide a 30 bed statewide psychiatric unit providing care for psychiatrically disabled prisoners who don’t require inpatient treatment, but are too disabled to be cared for by a primary care prison health service.

The acute component of prison psychiatry which focuses on assessment, early treatment and referral is to be located together with the prisoner reception function, at the publicly operated Melbourne Assessment Prison (MAP). This 15 bed acute assessment unit performs a critical gatekeeping function providing advice to Sentence Management staff on the preferred placement of prisoners, eg. placement at the MMP psychiatric unit or inpatient treatment at the state Forensic Psychiatry inpatient facility operated by the Department of Human Services.

Table 2

This table outlines the prisoner health service profile and identifies admission/discharge responsibilities.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PROVIDER</th>
<th>BEDS</th>
<th>RESPONSIBILITIES FOR ADMISSION &amp; DISCHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Private prison operators &amp; Public Corrections Agency</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Secondary care hospital (On site at the Mens Metropolitan Prison (MMP))</td>
<td>MMP operator through the Accredited Health Care Provider(s) (AHCP(s))</td>
<td>20 +2</td>
<td>Director of Clinical Services (DCS) of the MMP Hospital</td>
</tr>
<tr>
<td>Secondary hospital services (Female)</td>
<td>Women’s prison operator through its AHCP(s) or MMP operator through its AHCP(s)</td>
<td>-</td>
<td>Women’s prison operator through it AHCP or the DCS of the MMP hospital</td>
</tr>
<tr>
<td>Tertiary hospital services (Male)</td>
<td>MMP operator through its AHCP(s)</td>
<td>-</td>
<td>DCS at MMP hospital</td>
</tr>
<tr>
<td>Tertiary hospital services (Female)</td>
<td>Women’s prison operator through its AHCP or MMP operator through its AHCP(s)</td>
<td>-</td>
<td>Women’s prison operator through its AHCP or DCS at MMP hospital</td>
</tr>
<tr>
<td>Tertiary hospital - special services, eg Peter MacCallum, RVEEH, Mercy</td>
<td>Specialist tertiary hospital by arrangement with MMP operator</td>
<td>-</td>
<td>Admitting Medical Officer of relevant tertiary hospital.</td>
</tr>
<tr>
<td>Tertiary hospital services in emergencies</td>
<td>Local hospitals (mostly rural) by arrangement with prison operators/managers</td>
<td>-</td>
<td>Local hospital Admitting Medical Officer in consultation with local primary care provider</td>
</tr>
</tbody>
</table>

+ Note: Plus 2 observation rooms each with a single bed.
+ Note: Provision for potential expansion up to 25 beds (additional 5 beds)
Table 3

This flow chart depicts the new arrangements for statewide psychiatric services

PRISONERS WITH PSYCHIATRIC ILLNESS
INDICATIVE FLOW ARRANGEMENTS

ACUTE ASSESSMENT UNIT
(MELBOURNE ASSESSMENT PRISON)

Prison Reception

Referral during imprisonment (from any prisons)

Institute of Forensic Mental Health

Freedom

Psychosocial Unit, MMP

As Classified and Freedom

Mainstream Prisons (Primary Care Service)

As Classified and Freedom

Other:
  - Freedom
  - Court
  - Disability Services
Table 4
This table outlines the statewide prison psychiatric service profile and identifies admission/discharge responsibilities.

<table>
<thead>
<tr>
<th>PRISON PSYCHIATRIC SERVICES</th>
<th>PROVIDER</th>
<th>BEDS</th>
<th>RESPONSIBILITY FOR ADMISSION &amp; DISCHARGE</th>
<th>LEVEL OF DISABILITY</th>
<th>LEVEL OF INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institute of Forensic Mental Health</td>
<td>Department of Human Services (in the gazetted in-patient psychiatric facility)</td>
<td>120</td>
<td>Director of Forensic Psychiatry</td>
<td>acute mental illness; non-compliance with medication</td>
<td>full range of in-patient psychiatric treatment</td>
</tr>
<tr>
<td>Acute Assessment Unit (AAU) at Melbourne Assessment Prison (MAP)</td>
<td>Department of Human Services and CORE - Public Correctional enterprise</td>
<td>20</td>
<td>Director of Forensic Psychiatry in consultation with classification</td>
<td>suspected mental illness; acute self-harm</td>
<td>assessment; continuing treatment if compliant</td>
</tr>
<tr>
<td>Psychosocial Unit (PSU), Mens Metropolitan Prison (MMP)</td>
<td>MMP Operator through its AHCP</td>
<td>30</td>
<td>Admitting Medical Officer PSU in consultation with sentence management</td>
<td>chronic mental illness; vulnerable; prone to relapse compliant</td>
<td>specialist support and continuing treatment</td>
</tr>
<tr>
<td>Primary Care Health Services</td>
<td>Private Operators; CORE</td>
<td>-</td>
<td>As Classified</td>
<td>stable; compliant</td>
<td>limited intervention; client self-management; GP oversight; relapse prevention</td>
</tr>
</tbody>
</table>

Note: Plus 3 high observation/seclusion rooms, each with a single bed.

(c) Service specifications and policy settings:

Attachments 1-3 contains the service specifications for primary care (applying to all prisons), secondary and tertiary care (applying primarily to the MMP prison hospital and psychiatric unit but also to tertiary service linkages) and health services for women.

The umbrella specification or “outcome” is simply that “Health care facilities and services are provided for prisoners to a community standard, while also taking into account the special health needs of prisoners”. The balance of the requirements are best described as rules and standards to apply to service provision rather than actual “outputs”. The key features are -

(1) The correctional operator providing the secondary care prison hospital with its associated tertiary services is required to sub-contract this service to an “Accredited Health Care Provider” (AHCP). An AHCP is defined as a “Health Care Provider which currently operates a health care facility to a standard which permits accreditation by the Australian Council of Health Care Standards”.

This requirement has two clear policy objectives, namely, ensuring that there is a separation between correctional management and the State’s major prison health care operation, and that the health care operator is in fact a publicly recognised health provider in whom there can be public confidence.
(2) That the health service in each prison is accredited by the ACHCS within a period of 2/3 years and maintains that accreditation.

The policy intention is self evident, ensuring that by means of external accreditation a formal endorsement of the quality of the service is evident and stringent Q.A. programs are in place.

(3) The responsibility for standards setting, and monitoring service performance and standards compliance, rests with the Health Minister (currently the Department of Human Services) by virtue of a specific Cabinet decision. This policy requirement recognises that health care provision in prisons is not only a vital component of an effective prison system, but that it is a specialist business different from correctional management. It is designed to promote public confidence in prison health care provision, by ensuring that relevant and contemporary health expertise is applied to the monitoring task.

(4) Case management in the form of a demonstrated systematic approach to care management including release planning and referrals is required.

(5) Health care services must not be provided without the informed consent of the prisoner. There are limited exceptions, eg. involuntary transfer to psychiatric inpatient service for treatment.

(6) Health files must be maintained in accordance with public hospital standards ensuring confidentiality to health care personnel.

(7) Prisoner labour is not to be used for health care programs except in peer education.

(8) Women prisoners must have access to the services of a female doctor.

(9) Newly received prisoners must receive a health assessment within 24 hours of admission.

(10) Health decisions must be determined on clinical grounds and by appropriately qualified staff.

(11) A range of specifications requiring compliance with specific legal and health professional requirements eg. clinicians to be qualified and registered, pathology services to be provided only by organisations accredited by the Victorian Pathology Accreditation Board etc.

d) Specification of minimum service levels:

Eligibility for particular health services must be standardised across all prisons eg. entitlements for dental care (beyond emergency pain relief and fillings) and optometry (essentially glasses and contact lenses). In addition, the methadone program guidelines apply to all prisons.
e) The Health Monitoring System:

An important part of the prison health care model is the role of the Department of Human Services in service monitoring. The Department has established a Prison Health Care Standards and Monitoring Unit headed up by a senior officer with strong linkages into the Department’s Public Health and Aged, Community and Mental Health programs. The Unit works closely with the Office of the Correctional Services Commissioner (OCSC) and performs its highly specialised role through -

- assessment of monthly reports from service providers (medical officer appointments, prescription profiles, Consultant appointments, health education programs etc);
- conduct of clinical audits using an independent external specialist physician;
- investigation of prisoner complaints regarding health care;
- non-clinical audits against service proposals on hours of service delivery, professional registration, validation of monthly reporting items, etc;
- conduct of patient satisfaction surveys;
- discussion with prisoners.

The monitoring program recognises that the Department and the health providers are new partners and that neither is fully aware of the other’s expectations and demands. The Monitoring Unit therefore starts with a fairly inspectorial approach initially and, depending on the results of that approach, will decrease the level of intrusion.

The Unit therefore encourages health providers to develop and enhance their own quality assurance and accreditation programs. QA and accreditation programs at each prison are required under the health care specifications so that, ideally, the providers become their own monitors. This creates a balance where providers do not feel that the Department is constantly looking over their shoulders; the Department is satisfied that health services are maintained at a level recognised nationally as an accredited standard and, not least, prisoners receive a community standard of health care service.

The monitoring program also dovetails in with the Department of Justice’s monitoring requirements for custodial services and while many aspects of the program are unique to health care, the general model owes much to the program developed by the Office of the Correctional Services Commissioner. This has the advantage of allowing the health monitoring program to use the same reporting lines as the custodial monitoring program, so that, if appropriate, the Department of Justice can impose penalties or award bonuses.

One difficulty encountered in establishing the monitoring program has been the identification of an appropriate set of prisoner health care standards. There are no nationally accepted standards completely appropriate to the area. I will discuss this in more detail later in this paper.
f) Provision of policy advice by the Department of Human Services:

This function is distinct from the monitoring activity and is intended to inform the OCSC on emerging health issues which might range from new models of care, to funding formulae, needle exchange programs, methadone policy and substitute pharmacotherapies etc. The policy intention is to ensure that prison health care remains in the mainstream of contemporary health care knowledge, thinking and developments.

Progress on service system implementation May 1997

- Metropolitan Womens Prison Deer Park (125 beds) - opened September 1996
  Health care provider Brimbank Community Health Centre Inc.

- Fulham Prison at Sale (600 beds) - opened March 1997
  Primary health care provided through Australian Correctional Management and Wellington Healthcare Group

- Mens Metropolitan Prison (600 beds) Laverton - due to open September - December 1997
  Health care provider - Primary Care, statewide prison hospital and psychiatric unit - St. Vincents Hospital

- CORE - Public Corrections facilities health care to be **outsourced effective 1/1/98.** Service(s) to go to tender mid 1997

- Department of Human Services Prison Health Service - Statewide Pentridge Hospital and country (publicly operated) prisons health services to cease operation 31st December 1997.

- Melbourne Assessment Prison (statewide reception function - DHS provided health service including acute psychiatry program - to be outsourced effective 1/1/99. Likely to go to tender mid 1998.

As part of the governments’ total redevelopment of health services for prisoners, a new Victorian Institute of Forensic Mental Health will soon commence construction in Melbourne. This 120 bed inpatient secure hospital and associated facilities will provide psychiatric treatment for seriously mentally ill prisoners and offenders. The management auspice is yet to be determined, but the Health portfolio will be the service purchaser. The institute will open in the final quarter of 1998. In addition, a 15 bed facility for intellectually disabled clients will be constructed on a site adjacent to the hospital. This facility will provide residential treatment services for intellectually disabled clients requiring a high level of security.

**Note** The new Forensic facility will include a **15 bed purpose designed unit for female offenders.**
Health Care for Women Prisoners

Women prisoners present special challenges for health care provision both in terms of the complexity of their needs and their demand for services. Service specifications ensure that there is an appropriate level of services provided and that it is at least equivalent to those provided formerly through the public operator at Fairlea. The present health provider is a large western suburbs Community Health Centre (Brimbank CHC Inc). The provider is familiar with, and expert in, provision of holistic health related services to patients, many of whom suffer from multiple disadvantage. Whilst the service is new to the prison, initial indications are that the community health approach to health service provision will prove both engaging for prisoners and effective in the prison environment.

As noted earlier, the Government intends to rectify a longstanding gap in forensic service for women in Victoria. Rates of mental illness and behavioural disturbance in this population are high. The new Victorian Institute of Forensic Mental Health due to open late 1998 will provide dedicated appropriate accommodation and treatment for up to 15 women.

Emerging Issues - Where to from here?

The service reform process to date has taken 3 years in developing the critical service system design, service specifications and monitoring system. This service redevelopment task has involved much forging of new ground and in doing so several issues have emerged that providers of Correctional Services nationally may find of special interest.

Firstly, whilst no one will be surprised to hear that the actual detailing of the service specifications and standards was a difficult task, the process did reveal two very major deficiencies in prison health care in Australia - lack of any national standards for this specialised area of health care, and lack of a proper epidemiological data base for strategic targeting of health resources in prisons. The lack of both is indicative of the neglect which tends to characterise this area of health care delivery both in Australia, and overseas, by both health researchers and service planners alike.

Much work has been done in the U.S on standards, driven largely it seems by successful litigation concerning historically inadequate health care in US prisons - this material is available and we have utilised it in Victoria. It represents a sound basis on which Australian standards could be developed. Encouragingly there is some local interest in this issue, and the Federal Branch of the Australia Medical Association has responded positively to Victoria’s suggestion that such a set of standards would be a valuable contribution to prison health.

A benchmark set of national standards with some form of in-principle agreement from State Correctional/Health agencies would contribute to the quality of prison health care in Australia. In a timely manner it would also provide some framework for prison health care service redevelopment during this phase of structural reform, which is unlikely to remain confined to Victoria.

Targetting health care based on good knowledge of health needs makes sound economic and health care sense. We “know” anecdotally about the “special needs” of prisoners and you will recognise this term in our “outcome” specification statement mentioned earlier - clearly we mean drug abuse, mental health issues etc. The fact is that we do not know, in
any systematic way, the health profile of Australian prisoners. We know that they tend to be a disadvantaged population, and in the case of women, a particularly disadvantaged population. We know too about Hepatitis C infection rates, although we know worryingly less about the implications. An international literature review commissioned by Victoria into the state of epidemiological knowledge about prisoners simply confirmed that there has been no systematic investigation anywhere, nor does it appear that there is a data base under development anywhere. A solid epidemiological initiative and the development of a decent data base in Australia should not be that difficult and it needs to be done.

Finally, our experience over the last 2 years or so in reforming and moving to outsource our system in Victoria has highlighted the desirability of having a national (for reasons of cost sharing and effectiveness) research and training capacity in prison/custodial health. Our prison health systems around Australia are individually too small to support or justify local bodies dedicated to this service. Certainly in a competitive multiprovider correctional and prison health system this type of resource would be of enormous practical assistance in supporting the new entrants to the prison health care field. The concept of course is not new and was floated in 1991 at the first national conference on Corrections Health. It is timely to revisit a proposal that could be funded on a multi-contributor basis by the states and the major private correctional operators. A national body with strong university linkages could generate revenue through fee-for-service training and service development/service evaluation consultancies. In addition, it could address key issues from service benchmarking to pursuit of an epidemiological data base on Australian prisoners.

In conclusion, Victoria’s new prison health service system is only partially implemented with the largest and most complex components yet to be put into place. In the Australian context at least, the totally outsourced multiprovider system design is leading edge and contains all the ingredients to ensure that this State yet again sets the national benchmark in prison health care.

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1 Certainly the UK have lead the field in surveying health related issues of prisoners (Bridgwood and Malbon) and we await with interest the outcome of a similar survey of NSW prisoners by the NSW Corrections Health Service.
ATTACHMENTS

Prison Health Care Specifications -

Women’s Services

Men’s Services

Secondary and Tertiary Level Services
APPENDIX 1

PRIMARY LEVEL HEALTH CARE SERVICES

WOMEN’S HEALTH CARE

Outcome

Health care facilities and services are provided for prisoners to a community standard, while also taking into account the special health needs of women prisoners, which include access to the services of a female doctor.

Outputs

The prison health care service:

(a) co-ordinates and provides health care and medical services, which observe accepted clinical standards and are consistent with accepted community health care practices, and which take into account the special health care needs of women prisoners, including access to the services of a female doctor;

(b) ensures that prisoners in psychiatric crisis receive immediate psychiatric services or emergency psychiatric care;

(c) ensures that prisoners with psychiatric disabilities, or who are at psychiatric, risk receive appropriate clinic services including referral to Forensic Psychiatric Services for consideration of admission to a secure hospital;

(d) ensure that prisoners who are at risk to themselves through self injury or suicide receive immediate treatment and management, including referral for ongoing treatment services;

(e) ensures that medication, particularly psychotropic and codeine based medication, is issued in a responsible and profession manner;

(f) is responsible for comprehensive health, medical and psychiatric case management including release planning and referrals to community agencies;

(g) provides infection control programs including the education of staff and prisoners in infection control;

(h) ensures that infected or potentially infectious prisoners and staff are managed, counselled, referred and tested as required;

(i) provides optometry, physiotherapy and dental services;

(j) enters into an arrangement which provides the authority for duly qualified medical practitioners to manage a methadone program;

(k) ensures that appropriate arrangements are made and suitable procedures are in place for the admission of prisoners to public hospitals for in-patient and out-patient services;
(l) ensures that requests from any prisoner are dealt with in accordance with the relevant legislation, policy and ethical standards on patient confidentiality;

(m) provides a comprehensive health, medical and psychiatric screening assessment for all prisoners upon initial reception into the prison including testing for infectious diseases and dental assessments;

(n) ensures that children who remain with their care-giver in prison are provided with access to Medicare and other health services;

(o) allows children, were practical, to receive health and medical service at the normal place of practice of the health care practitioner;

(p) provides acute care and treatment services, rehabilitation programs and release preparation programs;

(q) ensures health decisions are determined only by qualified health staff;

(r) develops and implements quality assurance programs, across all disciplines and facilities in accordance with the requirements of the Australian Council of Health Care Standards; and

(s) maintains clinical and health files in accordance with public hospital standards ensuring confidentiality to health care personnel.

Policy Requirements

The service must ensure that all prisoners initially received into the prison or received after transfer from another location are medically checked as soon as possible after reception, and not later than 24 hours after reception and have access to a female doctor for this purpose.

The service must obtain accreditation for the health care facilities and services, from an agreed authority body in health care standards, and such accreditation must be maintained and a satisfactory assessment obtained every two years.

The prison health care service must:

(a) allow a prisoner, with the approval of the principal medical officer, to choose their own private medical officer, physiotherapist or chiropractor at the prisoner’s own expense;

(b) not charge for any medical, health or psychiatric care;

(c) pay the costs of care, treatment, pharmaceutical and other expenditure associated with admissions to hospitals other than the contracted secure ward for tertiary health care services;

(d) not issue, prescribe, or dispense methadone except to prisoners who are already on an established methadone program and who are:
(i) on remand;
(ii) serving a total sentence of less than six months;
(iii) pregnant; or
(iv) on a methadone reduction program;

(e) not provide any medical or psychiatric services except:

(i) with the informed consent of the prisoner;
(ii) for the purposes of certification under the Mental Health Act; or
(iii) placement in a particular unit or cell for medical or psychiatric observation;

and

(f) not use prisoner labour in the provision of health care, medical or psychiatric services except in the provision of peer education programs.
PRIMARY LEVEL HEALTH CARE SERVICES

MEN’S HEALTH CARE

Outcome

Health care facilities and services are provided for prisoners to a community standard, while also taking into account the special health needs of prisoners.

Outputs

The prison health care service:

(a) co-ordinates and provides health care and medical services, which observe accepted clinical standards and are consistent with accepted community health care practices, and which take into account the special health care needs of prisoners;

(b) ensures that prisoners in psychiatric crisis receive immediate psychiatric services or emergency psychiatric care;

(c) ensures that prisoners with psychiatric disabilities, or who are at psychiatric risk, receive appropriate clinical services including referral to Forensic Psychiatric Services for consideration of admission to a secure hospital;

(d) ensures that prisoners who are at risk to themselves through self injury or suicide receive immediate treatment and management, including referral for ongoing treatment services;

(e) ensures that medication, particularly psychotropic and codeine based medication, is issued in a responsible and profession manner;

(f) is responsible for comprehensive health, medical and psychiatric case management including release planning and referrals to community agencies;

(g) provides infection control programs including the education of staff and prisoners in infection control;

(h) ensures that infected or potentially infectious prisoners and staff are managed, counselled, referred and tested as required;

(i) provides optometry, physiotherapy and dental services;

(j) enters into an arrangement which provides the authority for duly qualified medical practitioners to manage a methadone program;

(k) ensures that appropriate arrangements are made and suitable procedures are in place for the admission of prisoners to public hospitals for inpatient and outpatient services;
(l) ensures that requests from any prisoner are dealt with in accordance with the relevant legislation, policy and ethical standards on patient confidentiality;

(m) provides a comprehensive health, medical and psychiatric screening assessment for all prisoners upon initial reception into the prison system including testing for infectious diseases and dental assessments;

(n) ensures health decisions are determined only by qualified health staff;

(p) develops and implements quality assurance programs, across all health disciplines and facilities, in accordance with the requirements of the Australian Council of Health Care Standards;

(q) maintains clinical and health files in accordance with public hospital standards ensuring confidentiality to health care personnel; and

(r) is responsible for ensuring that seriously mentally ill prisoners are assessed by a psychiatric professional and, when appropriate, referred to Forensic Psychiatric Services for consideration of admission to a secure hospital.

Policy Requirements

The service must ensure that all prisoners initially received into the prison system or received after transfer from another location are medically checked as soon as possible after reception, and not later than 24 hours after reception.

The service must:

(a) allow a prisoner, with the approval of the principal medical officer, to choose their own private medical officer, physiotherapist or chiropractor at the prisoner’s own expense;

(b) not charge for any medical, health or psychiatric care;

(c) not issue, prescribe, or dispense methadone except to prisoners who are already on an established methadone program and who are:

(i) on remand;
(ii) serving a total sentence of less than six months; or
(iii) on a methadone reduction program;

(d) not provide any medical or psychiatric services except:

(i) with the informed consent of the prisoner
(ii) for the purposes of certification under the Mental Health Act; or
(iii) placement in a particular unit or cell for medical or psychiatric observation; and
(e) not use prisoner labour in the provision of health care, medical or psychiatric services except in the provision of peer education programs.

The service must comply with health care standards set and monitored by the Department of Human Services.
APPENDIX 3

SECONDARY AND TERTIARY LEVEL HEALTH CARE SERVICES

Output

The Contract Provider must provide Secondary Care health facilities. The Contracted Provider must provide for Secondary Care and Tertiary Care services that meet the health, medical and surgical and psycho-social needs of Victorian prisoners which will be delivered by an Accredited Health Care Provider(s).

Legislative and Policy Requirements

A  Australasian Policy Statements

Royal Commission into Aboriginal Deaths in Custody
(Recs. 130, 150-7) 1991

B  Statements by the Professional Associations

Physicians

The Hippocratic Oath 5 BC
The Declaration Of Geneva (WMA) 1948, 1968, 1983
International Code of Medical Ethics (WMA) 1949, 1968, 1983
Declaration of Tokyo (WMA) 1975
Resolution of the WMA on Physician Participation in Capital Punishment 1981
Regulations in Times of Armed Conflict (WMA) 1956, 1957, 1983
Declaration on Hunger-Strikers (WMA)

Psychiatrists

Declaration of Hawaii (WPA) 1977, 1983

Nurses

Role of the Nurse in the Care of Detainees and Prisoners (ICN) 1975
Nurse's Role in Safeguarding Human Rights (ICN) 1983

C  Codes and Statements by the United Nations

Principles of Medical Ethics 1982
Declaration Against Torture 1975
Standard Minimum Rules for the Treatment of Prisoners 1955, 1977
UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care
International Covenant on Civil and Political Right
D Declarations by Amnesty International

Declaration of Stockholm 1977
Declaration on Participation of Doctors in the Death Penalty 1981

E Statutory Requirements

Relevant Federal Acts and Regulations.

All Victorian Acts and regulations, including-

Adoption Act 1981
Alcoholics and Drug-dependant Persons Act 1968
Ambulance Services Act 1986
Cancer Act 1958
Cemeteries Act 1958
Children and Young Persons’ Act 1989
Children’s Court Act 1973
Chiropodists Act 1968
Chiropractors and Osteopaths Act 1978
Community Services Act 1970
Corrections Act 1986
Dental Technicians Act 1972
Dentists Act 1972
Dietitians Act 1981
Disability Services Act 1991
Drugs, Poisons and Controlled Substances Act 1981
Food Act 1984
Freedom of Information Act 1984
Health Act 1958
Health (Fluoridation) Act 1973
Health Services Act 1988
Health Services (Conciliation and Review) Act 1987
Human Tissue Act 1982
Infertility (Medical Procedures) Act 1984
Intellectually Disabled Persons’ Services Act 1986
Medical Practice Act 1994
Medical Practitioners Act 1970
Medical Treatment Act 1988
Mental Health Act 1986
Nurses Act 1958
Nurses Act 1993
Optometrists Registration Act 1958
Pathology Services Accreditation Act 1984
Pharmacists Act 1974
Physiotherapists Act 1978
Psychological Practices Act 1965
Psychologists Registration Act 1987
Sentencing Act 1989
State Concessions Act 1986
Tobacco Act 1987
Overview

The Contracted Provider will be responsible for the provision of Secondary Care and Tertiary Care Services through Accredited Health Care Provider(s). The Contracted Provider is to provide facilities for Secondary Care Services.

In the case of multiple providers of Secondary Care and/or Tertiary Care Health Services, the Contracted Provider is to nominate which is to be the principal provider. The Contracted Provider will ensure a co-ordinated, seamless and integrated Secondary and Tertiary Care Service.

The Contracted Provider is to provide custodial management of prisoners in the secondary and tertiary hospital facilities.

The Contracted Provider will provide for a total, efficient, effective and accessible secondary and tertiary health service to prisoners at a community standard while taking into account the special health care needs of prisoners.

The Department of Health and Community Services (H&CS) will set standards for the provision of prisoner health care services and monitor compliance with those standards.

Secondary Care and Tertiary Care Services

The Contracted Provider will ensure that consultant services are provided. A consultant service is one to which a patient is referred from primary care services for medical, surgical or psychiatric investigation and/or management.

The Contracted Provider will, in consultation with an Accredited Health Care Provider, design and construct a twenty bed prison hospital and a thirty bed psycho-social unit which, together with a tertiary hospital service, will meet the medical, surgical and psycho-social needs of all Victorian prisoners.

The Department of Health and Community Services will continue to provide gazetted forensic psychiatric in-patient services (at the Institute of Forensic Psychiatry) and prison based acute assessment services (in the Melbourne Reception Centre) for male prisoners.

The Contracted Provider must provide Secondary Care prison hospital services to, at least, the minimum levels described in table 1, p 9. The Contracted Provider may choose to provide prison based hospital services at a higher level than described. The service levels have been set utilising the “Guide to the Role Delineation of Health Services”, as amended, first published by the NSW Health Department in June 1991.

Utilisation rates for Secondary and Tertiary Care Services are detailed in Appendix 1.
Table 1. Required minimum levels for Secondary Health Care Services.

<table>
<thead>
<tr>
<th>Secondary Health Care Services</th>
<th>Required Minimum Level</th>
<th>Secondary Health Care Services</th>
<th>Required Minimum Level</th>
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<tr>
<td><strong>Clinical Support Services</strong></td>
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<td>Emergency Services</td>
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<td>1</td>
<td>Endocrinology</td>
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<tr>
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<td>2</td>
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<tr>
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<td>Infectious Diseases</td>
<td>2</td>
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<tr>
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<td>Oncology - Medical</td>
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</tr>
<tr>
<td></td>
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<td>Renal Medicine</td>
<td>2</td>
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<tr>
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<td>Rheumatology</td>
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</tr>
<tr>
<td></td>
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<td>Burns</td>
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<td></td>
<td></td>
<td>Day Surgery</td>
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<td>Gynaecology</td>
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<tr>
<td></td>
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<td></td>
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<td>Plastic Surgery</td>
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<td></td>
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<td>Vascular Surgery</td>
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<td>Neonatal</td>
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<tr>
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<td>Paediatric Surgery</td>
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<td><strong>Community Health Services</strong></td>
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<td>Aboriginal Health</td>
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</tbody>
</table>
| **Pathology service must also be accredited by the Victorian Pathology Accreditation Board.**
| **To provide a statewide advisory service to all prisons.**
| **Not including Local Trauma Service, which is not required on site.**
| **Not including Endoscopies, which are not required on site.**

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Children will not be admitted to the MMP prison hospital.

Not including training to doctors.

Allied health staff may be on-call or sessional.

Required to address prison health-related recommendations arising from the Royal Commission Into Aboriginal Deaths In Custody and allow Aboriginal prisoners a choice of utilising an Aboriginal Health Service.

Psycho-Social Unit (PSU)

The Contracted Provider must provide multi-disciplinary care facility and treatment services for up to 30 prisoners with long standing but controlled mental illness. The Unit must aim to return prisoners to mainstream prison, to provide programs to enhance prisoners’ mental health and social rehabilitation and/or pre-release preparation programs.

Appendix 4 outlines the current programs of the Psycho-Social Unit which is located at the Coburg complex. This is provided for information and is not necessarily the way in which the future service will be provided.

General requirements for secondary and tertiary care

Accreditation

The Contracted Provider must by arrangement with the Accredited Health Care Provider(s) apply within 18 months of commissioning of the prison for three year accreditation of the Secondary Care prison hospital facility from the Australian Council of Health Care Standards (ACHCS).

The Contracted Provider will ensure that accreditation is achieved within three years of commissioning and once accredited the 20 bed prison hospital maintains continuous accreditation from the ACHCS.

Costs and Charges

The Contracted Provider will meet the costs of all necessary treatments, drugs, aids or appliances and all medical, surgical, health or psychiatric care supplied by the Contracted Provider.

The Contracted Provider will not charge prisoners for any of these goods or services.

Medication

The Contracted Provider must ensure that the management of medication, particularly psychotropic and codeine based medication, is conducted in a responsible legal and professional manner.
Case Management

The Contracted Provider is responsible for comprehensive health, medical and psychiatric case management including release planning and referrals to community agencies.

Records and Reports

The Contracted Provider must provide, on request, in respect of any prisoner or former prisoner, in accordance with legislative requirements, policy, guidelines and ethical standards on patient confidentiality, written and verbal psychiatric, psychological, medical and management reports and advice to the Principal Medical Officer.

The Contracted Provider must maintain clinical and health care records in accordance with public hospital standards and ensure confidentiality to health care personnel.

The Contracted Provider should be aware that their attendance and reports may be subpoenaed by Courts on a regular basis.

All prisoner clinical records and reports remain the property of the Government.

Standards

The Contracted Provider must:

satisfy “good operational practices”. “Good Operational Practice” means practices which are undertaken:

a) with the level of due care and skill required by nationally accepted hospital operating and management procedures’ with due expedition and without unnecessary or unreasonable delays;

b) in a manner that facilitates good clinical practice and an efficient operation; and

c) in accordance with all applicable laws, regulations and guidelines.

• comply with health care standards set by H&CS;

• comply with standards listed in the Standards Australia document “ A list of Australian Standards Health Care”, June 1995;

• Only provide medical, surgical or psychiatric services with the informed consent of the provider except:

  - for the purposes of certification, but not treatment, under the Mental Health Act 1986; or
  - for placement in a particular cell or unit for medical or psychiatric observation.

• provide pathology services through a laboratory accredited by the Victorian Pathology Services Accreditation Board;

• ensure health decisions are determined on clinical grounds and by appropriately qualified health staff
• not use prisoner labour in the provision of health care, medical, surgical or psychiatric services except in the provision of peer education programs.

**Transport**

Prisoners will generally be transported by the routine escort service to the MMP to attend outpatient consultations or admission to the hospital. Accordingly, they may be placed at the MMP prison awaiting out-patient appointments or awaiting the routine escort back to their classified prison. Routine transport is currently provided by the Office of the Correctional Services Commissioner through a contracted service.

Non-routine transportation and escorts to and from out-patient consultations or admission to MMP Hospital or local hospitals are the responsibility of the prison from where the prisoner originated.

The Contracted Provider will provide custodial management, transport and escorts for MMP prisoners referred to tertiary hospitals. This includes prisoners from other prisons transferred to MMP for medical consultations which then lead to further referrals to tertiary facilities.

**Women Prisoners**

Women prisoners may be referred for admission to the secure tertiary hospital facility for acute medical, surgical or psychiatric care and/or treatment. The Contracted Provider will be responsible for the cost of care provided to women prisoners admitted to the tertiary hospital facility.

Women prisoners may, from time to time, be admitted into the MMP hospital if there is no other suitable placement for the management and treatment of the prisoner. Women prisoners admitted to MMP hospital will not share wards with male prisoners.

Women prisoners will not be referred or admitted to the Psycho-Social Unit.

**Aboriginal Prisoners**

The Contracted Provider will provide Aboriginal prisoners with the choice of utilising an Aboriginal health service provider in addition to other prisoner health care services.

**Staff**

The Contracted Provider must ensure that psychiatrically disturbed or vulnerable prisoners are appropriately managed and referred by custodial officers.

The Contracted Provider in collaboration with the Royal Australian & New Zealand College of Psychiatrists must facilitate opportunities for training in forensic psychiatry within Secondary Care facility or the Psycho-Social Unit.

**Clinical Coordination**

Central co-ordination and clinical advice for statewide primary health care providers will be provided by the Director of Clinical Services at the MMP hospital who will also co-
ordinate out-patient consultations at the MMP hospital and tertiary facilities. The MMP hospital will provide a statewide advisory service on other prison health matters, such as, the use of pharmaceutical’s.

The Contracted Provider will ensure that MMP psychiatric services are effectively linked with other statewide forensic psychiatric services which are centrally co-ordinated by the Director of Forensic Psychiatry.

**Monitoring of Health Care Standards**

The Office of the Correctional Services Commissioner has responsibility for monitoring standards across the prison system. H&CS will also have responsibility for monitoring health care standards in public and private prisons. Appropriate liaison arrangements will be established between H&CS and the Commissioner’s office to ensure an integrated monitoring system.

**REFERENCES**

Bridgwood A, Malbon G “Survey of the Physical Health of prisoners 1994” Office of population censuses and survey UK