Assessment of Clinical Service Provision of Health Services of the Western Australian Department of Corrective Services
Executive Summary

In 2009 the Department of Corrective Services initiated a review of the clinical services provided by its Health Services Directorate. The Department sought independent advice on the structure of the Directorate and delivery of its clinical services.

Providing health services in a custodial facility is complex and often difficult. The environment is physically and socially restrictive and itself may pose health risks to the prisoner, such as the risk of communicable disease. The population has a high burden of disease and a high prevalence of health risk factors along with behavioural problems that can hinder assessment and treatment. Prison health services aim to deliver services which mitigate these health risks, respond to existing and new illnesses and are appropriate to the gender, ethnicity and age of the prison populations.

The WA prison health service has many positive features which compare well with interstate services:

- Enthusiastic and professional nursing staff provide health services in every prison and detention centre, with fulltime or part-time medical support.
- There is a screening and medical review of every prisoner and detainee at admission.
- A centralised pharmacy provides blister packed medications for all patients; this allows suitable offenders to carry their own medications, frees nurses from dispensing all medications and reduces medication error.
- Centralised management which sets and monitors clinical policies and standards of practice.
- Core programs that are appropriate to the health needs of the prisoner population – a co-morbidity program (to address mental illness and addictions); a communicable diseases program; a chronic disease program; and acute care services which respond to the daily health needs of offenders, provide initial screening and assessment, administer medications and respond to emergencies.

Broad consultation was undertaken with Directorate staff and many of the 27 recommendations reflect their thoughtful and professional input. The review endorsed the current broad structure of the Directorate and the existing core clinical programs. However, the Department of Corrective Services is a service of continual improvement and improvement is both necessary and achievable within Health Services.

Key recommendations relate to clinical staffing, with work required to stabilise and support the clinical workforce and re-establish leadership, professional development and career paths for nursing staff. Public health expertise in the Directorate should be re-established, to provide direction and leadership in communicable disease control, chronic disease control, data collection and targeted research. The core clinical programs require review and the scope of each program needs to be defined and competencies for staff working in
those programs need to be identified and developed. Work is required to further develop the co-morbidity program and to update its clinical protocols, practices and staff competencies. Health programs for Aboriginal people and for young people need to be developed and the women’s health policy needs to be implemented. Systems that support safety and quality improvement could and should be better utilised.

The services to prisoners provided by the Health Services Directorate are critical to improving the health of prisoners and maintaining the health of the families and communities to which they will return. This review provides a strategic direction for the Directorate to improve its service delivery and so improve the health outcomes of its patients.
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1. BACKGROUND

1.1. Purpose

To audit and critically assess the clinical services provided by the Health Services Directorate of the Department of Corrective Services (HS, DCS), and to identify areas requiring in-depth review and improvement. The appraisal has focused on key areas of service provision and performance across the Health Service, and did not attempt to address all issues at all sites.

The Director, Health Services reports to the Deputy Commissioner, Offender Management and Professional Development (OMPD). The Deputy Commissioner commissioned this assessment.

1.2. Context

In 2006, the Inspector of Custodial Services released a report titled *Thematic Review of Offender Health Services*. In this report, the Inspector argued for the transfer of the health services located within the DCS to the state Department of Health (DoH). The justifications for this recommendation were:

- the real difficulties that the HS, DCS was having in meeting the health needs of prisoners
- the World Health Organisation (WHO) recommendations that health services for prisoners are best provided by dedicated independent health organisations
- the almost uniform movement across Australia to relocate prison health services from a custodial environment to a health environment.

In response, the DoH set up a taskforce which examined the potential gains to be made to the health of prisoners and the community should this transfer be made and programs delivered to prisoners be enhanced. The Departments’ response *Prison Health Services, Final Report* was released in June 2008. The first recommendation was that:

*Responsibility for the provision of prison health services to be transferred from DCS to DoH with agreed funding provided and formal transition to commence in 2008/2009.*

The DoH required additional funding of $20M recurrent per year. The transfer did not occur.

These events set the context within which this critical appraisal has been undertaken:

- Health Services will remain in the DCS for the foreseeable future
- active and immediate attempts at service enhancement are justified and needed, both to respond to the deficiencies documented in the DoH report and to ensure that the best and most appropriate health care is delivered to prisoners.
1.3. Methods

There are 15 main prisons in WA, and each has an in-house health centre managed by HS, DCS. Acacia prison is privately managed under contract to the DCS and its health centre is not managed by HS, DCS. Data on DCS managed health centres was collected by site visits to many of the regional and metropolitan prisons during which the infrastructure of the health centre was inspected and discussions held with staff.

Staff in head office provided information on their areas of expertise and programs delivered.

The Prison Health Service in Queensland was visited, and discussions were held with key staff from the ACT Corrections Health Program and NSW Justice Health.

Unstructured interviews were also held with key informants in the areas of prison health research and mental health.

2. HEALTH OF THE OFFENDER POPULATION

The prevalence of acute and chronic disease was documented in the 2006 report of the DoH taskforce, although the limited WA data required the reliance on the results of interstate surveys and studies.

2.1. Demographic Profile

- predominantly male
- high proportion is Aboriginal (around 40%), in some regional prisons over 90% of the population is indigenous
- a young population
- a small but growing population of physically disabled and frail men. In 1994, there were six male offenders aged 70-79 years, nil aged 80 years and over. In 2009 there were 27 male offenders aged 70-79 years and nine aged 80 years and over.

The socio-demographic profile for both male and female offenders is one of socio-economic disadvantage, characterised by poor educational achievement and unemployment or under employment. Female offenders often have histories of violence and abuse perpetrated against them and may be the primary carers of children.

2.2. Health Profile

The Health Department’s Prison Health Services, Final Report summarised the Australian data on offender health. The offender population has greater burden of disease, both physical and mental, than does the general community, with a high prevalence of diseases related to socio-economic disadvantage and chaotic lifestyles:

- mental illness including anxiety, depression, psychoses, suicidal
behaviour and insomnia

- drug addictions, including licit and illicit drugs
- harmful levels of alcohol intake
- blood borne viruses (BBV), in particular hepatitis B and C
- sexually transmitted infections (STIs)
- dental decay and gum disease
- smoking.

Although there has been no systematic study of the WA offender population, it is a reasonable expectation that the high proportion of indigenous people in WA prisons is associated with a relatively high prevalence of diabetes, renal disease and cardiovascular disease.

2.3. Health Care Imperatives

There are three broad objectives of a prison health service:

1. to ensure that the health status of prisoners is not worsened by their incarceration
2. to recognise and treat existing and new illnesses and ailments
3. to take the opportunity to assess and manage health conditions and influence risky behaviours\(^1\).

There is a further duty to the community to ensure that potentially poor health practices in prisons do not increase the prevalence of disease in the community when prisoners with communicable diseases and high risk behaviours are released.

Health Services provided in prisons should be of a standard that is commensurate with those provided in the community.

2.3.1. Health Risks of Incarceration

The WHO has identified communicable disease as a major risk to the health of prisoners and prison staff. Overcrowding, failure to recognise existing disease, a dearth of treatment and preventive measures all contribute to the risk of airborne, faecal-oral and blood borne infections. The impact of a major disease outbreak in a prison would be felt far beyond that prison\(^2\).

Subsequent reports by the WHO as part of the *Health in Prisons Project* have focused on mental health and drug addiction/dependence as health risks of particular relevance to prisons. In addition, in WA, lack of physical exercise and relative overeating have been seen to contribute to obesity, so increasing the risk of diabetes and heart disease.

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\(^2\) Levy M. Prison Health Services: should be as good as those for the general community. *BMJ* 315; 1394-5.
2.3.2. To recognise and treat existing and new illnesses

The necessity to provide clinical services to treat illness and injury in offenders has long been recognised, and this primary health care service forms the backbone of prison health services.

2.3.3. Opportunities for health improvement

For the majority of prisoners whose stay in prison is of short duration, prison provides a unique opportunity for health assessment and care and for high risk behaviours and chronic, perhaps silent, diseases to be identified and treated. This not only fulfils the duty of care of the State to the prisoner, but may enhance the prisoners’ ability to exist and succeed post-release, with a subsequent reduction in the risks to themselves and the community.

For long-stay prisoners, the State has a duty to optimise their health through health prevention and health care, as would be received in the community.

It would be ideal if each prisoner could be released from prison in better health than at admission.

3. HEALTH SERVICE PHILOSOPHY

There is a legal imperative to provide health services to prisoners. Under the Prisons Act 1981, prisoners are held in the care of the State, and the State has a duty of care to each prisoner. Part III section 6 of the Prisons Act 1981 sets out the definitions of medical officers and medical practitioners; Part IX section 95A requires the CEO to ensure the provision of medical services to each prisoner, and section 95B further sets out the duties of a medical officer.

The vision of WA Health Services is stated in the Strategic Directions Plan 2005-2010:³

‘Improve the health and wellbeing of patients along the Justice Health Care Continuum.’

The Mission is stated to be:

To work in partnership along the Justice Health Care Continuum to:

- assess health determinants and health needs
- conduct health assessments
- design health strategies and health services
- deliver primary acute health care
- deliver effective chronic disease management
- deliver preventive health care
- improve the effectiveness of health care
- measure and assess the effectiveness of health care delivery.

³ Department of Corrective Services Health Plan Strategic Directions 2005-2010
A set of guiding principles is also stated with respect to patients and staff.

In addition, there is a statement acknowledging:

*A prison is a community. We provide services in accordance with community standards and according to the needs of patients.*

The health care imperatives, set out in section 2.3 of this report, are clearly reflected in the strategic directions of the Strategic Plan.

In practical terms, Health Services provides primary health care services and access to (directly or by referral) secondary and tertiary services for offenders. Services are not provided to DCS staff.

Each of WA’s ten public adult prisons, two juvenile detention centres and three prison farms has a health centre. A health centre is planned for the new multi-security West Kimberley Prison currently being built in Derby. All offenders admitted to prison or juvenile detention are reviewed by nursing staff on receipt and again by a health service doctor within 28 days of admission, or sooner if required. This initial review identifies health conditions requiring care, medications and immediate medical needs. The ongoing clinical programs provided by health centre staff are:

- acute care
- chronic disease identification and management
- communicable disease identification, prevention and management
- a mental health/addictions program (the co-morbidity program).

Consistency of clinical practice, standards of care and clinical competency are determined via policies and procedures managed through a central office.

Prisons vary in the demographics of their population, their security level, local procedures, the demands that the Superintendent makes of the health centre and the extent to which the Superintendent will accommodate the needs of the health centre. In addition, prisons have varying access to community services which may supplement the core health services provided by the health centre. Local solutions are inevitably needed in the implementation of the services’ programs and policies to adapt to the restrictions and opportunities of the local environment.

### 4. CLINICAL PROGRAMS

Clinical services can be categorised as acute care services, communicable disease control, chronic disease control and mental health. Core services in these programs are generally delivered by health centre staff, with additional services provided by visiting community-based organisations and specialist in-reach.

#### 4.1. Acute Care

The backbone of the health service in prisons is the provision of acute care services to prisoners by nursing and medical staff. The acute care service
comprises:

*Nursing*

- Reception of offenders to the prison and initial screening (using the MDR1012).
- Client-initiated consultations, which may resolve the problem or result in referral to the doctor. Consultations are generally by a booked appointment to a nurse-run clinic.
- Emergency consultations and response.
- Medication rounds, to administer Webster-packed medications and dispense other medications.
- Methadone clinic (if there are no co-morbidity staff on site).
- Health education and health promotion.
- Fitness to travel assessments and transfer medications.
- Discharge summaries.

*Medical*

- Assessment of all new admissions to prison, within 28 days of admission, and appropriate management and/or referral.
- Primary care nurse referrals and client-initiated consultations, which may resolve the problem or result in referral to secondary or tertiary services.
- Review of patients on medication and patients with chronic disease management plans.

There is a feeling within Health Services that the scope of clinical practice in the larger health centres should be widened. The perceived benefits are cost savings by reducing transport of patients to outside health facilities, improved security and improved job satisfaction for clinical staff. An example of this objective is the recent installation of X-ray equipment at Hakea and Casuarina Prisons, and the potential use of the infirmary at Casuarina for the care of ill patients and step-down of patients discharged from hospital.

### 4.2. Chronic Disease Management

The prevalence of chronic disease and high risk behaviours in the offender population has led to the establishment of a systematic program run throughout the State.

*Screening, treatment and prevention*

The chronic disease program focuses on the chronic diseases of asthma, cardiovascular disease and diabetes. The framework for the program is based on:

- the identification of people with a chronic disease
- the improvement of health care for these people through individualised
management plans with clinical reviews over time

- encouragement of patients to take an active role in their own health care through education and problem solving skills
- support for clinicians by the provision of professional development, resources and skill enhancement
- the promotion of wellness and prevention strategies through risk awareness and health information activities for the general prison population.

**Staffing**

A staff member to coordinate the chronic disease program was employed in 2006. Early experience was that the program was poorly supported by clinical staff in health centres. As a result, it was decided in 2008/2009 to nominate a clinician at each site to take responsibility for the program. The chronic disease portfolio is invariably held by a nurse who adds the responsibility for chronic disease to his/her acute care duties, often with a small reduction in the time they devote to the acute care clinics. Designating a responsible person for the program has resulted in better care planning, networking with community programs, patient education and discharge planning. The overall time allocated to chronic disease management across the State is around 7.1 FTE.

At those sites which do not have a dedicated holder of the chronic disease portfolio, Hakea Prison, Wooroloo Prison Farm and until recently Eastern Goldfields Regional Prison, the program is poorly implemented.

### 4.3. Communicable Diseases

Blood borne viruses (hepatitis B, hepatitis C and HIV) and sexually transmitted diseases (STIs) are prevalent in the offender population. The majority of male offenders have tattoos and tattooing is actively practiced while in prison; injecting drug use is also reported.

The crowded conditions of prisons make the spread of other communicable diseases (not blood borne) within the prison not only likely to occur but hard to contain.

**Screening, treatment and prevention**

The Health Service policy on BBV testing states:

*BBV testing is available and on offer to all patients with informed consent, including but not limited to:*

3.1.1 *At their initial medical examination.*
3.1.2 *When risk assessment factors are identified.*
3.1.3 *As follow-up at three months and then six months.*
3.1.4 Following any risk exposure / behaviour.
3.1.5 On patient request.
3.1.6 At the time of their annual health assessment.

Blanket BBV screening of both adults and juveniles on entry must not be undertaken. Testing must be offered to all patients with identifiable risk factors. Any disclosure is confidential regardless of whether the risk factors occurred inside or outside of the prison environment.

The current BBV & STI Risk Assessment form must be completed to establish risk factors. For those with no obvious identifying risk factors, screening is not indicated unless it is specifically requested by the patient.

A similar approach is taken to testing for STIs, except in juveniles; due to the prevalence of infections, all juvenile females are treated with antibiotics and all males are tested, subject to consent being given.

All patients with hepatitis C are assessed for suitability for treatment and offered treatment if appropriate. Specialist medical and nursing support, plus provision of medicines, is by Royal Perth Hospital and Fremantle Hospital. STIs are treated when identified.

Educational programs (HIP HOP) are offered to all prisoners at all facilities; in regional areas these programs are provided by the Population Health Units (DoH) and in the metropolitan area by hepatitis WA which is contracted for these services. There is some patchiness in program delivery, depending on the staffing levels of the Population Health Units.

Staffing

Two project/policy officer positions in DCS head office support the provision of communicable disease prevention and treatment services to this population. These officers also facilitate the collection of data for the National Prison Entrants Bloodborne Virus and Risk Behaviour Survey, 2004, 2007 and 2010.

As with the chronic disease program, a nurse in each health centre holds the portfolio. There are regional differences according to the resources available. In Albany, a dedicated part-time hepatology nurse provides screening and treatment for BBVs; in Eastern Goldfields Regional Prison the screening program is staffed by monthly in-reach by a senior nurse and public health physician from the local Population Health Unit.

4.4. Mental Health/Addictions

4.4.1. The co-morbidity service

The co-morbidity service has grown out of the amalgamation of a small mental health service (with 4-5 mental health nurses) and 12 alcohol and drug clinicians, funded by new moneys in 2003 when the methadone program
commenced. A visiting psychiatrist in-reach service from the Frankland Centre was ceased in 2007 at which time DCS Health Services employed three psychiatrists.

The mental health program in prisons has been, and remains, contentious. Significant applications to Government for enhanced funding have been made jointly with the Department of Health and independently but none have been successful. The co-morbidity program is the pragmatic result.

**Screening, treatment and prevention**

The co-morbidity program is a secondary service, with patients referred by the primary care team, allied health or custodial staff. The assessment checklist administered to all offenders arriving in the prison system (the MDR 1012) contains four questions to identify persons at risk of addiction/mental illness.

The activities of the program are:

- AOD (alcohol and other drugs) and mental health assessments, including mental state examinations and completion of Form One (involuntary referral to a psychiatrist facility) if necessary
- case management as required
- counselling and support
- provision of advice to the primary care team and Prison Counselling Service
- through-care management and referral to tertiary and community AOD and mental health services
- pharmacotherapy prescribing, management and issue of pharmacotherapy
- prescribing and monitoring of psychotropic medication; administration of depot medications
- attendance and input into the management of prisoners at risk via ARMS (At Risk Management System), PRAG (Prisoner Risk Assessment Group) and SAMS (Support and Monitoring System)
- a group-based AOD program (a 10 session program) in some metropolitan prisons
- maintaining the Mental Health Register for tracking of patients with severe mental illness.
Staffing

The current co-morbidity program staffing is 17.5 FTE in clinical nursing positions, plus four medical officers and two non-clinical policy positions. The skills and designations of these clinical positions vary, reflecting the history of the program.

The psychiatrists and the medical officer (addictions) report administratively to the Manager Co-morbidity and professionally to the Director Health Services. The psychiatrists provide services at all metropolitan health centres and selected regional health centres. At Broome Regional Prison, for example, psychiatric services are provided by the North West Mental Health Services whereas a DCS Health Services psychiatrist visits Eastern Goldfields and Albany regional prisons. A psychiatrist from Graylands Hospital is employed at Hakea one day per week.

The 17.5 FTE comprises nursing staff of various levels and training:

- SRN1 (co-morbidity clinical specialist) at Albany, Bunbury, Roebourne, and Greenough prisons
- Level 5 enrolled nurse (co-morbidity clinical specialist) at Broome Regional Prison
- one SRN3 (clinical consultant co-morbidity), 3.2FTE x SRN1, a part-time nurse of the Prisons Addictions Service (PAST) and 2 mental health nurses at Hakea Prison. Hakea-based staff (1.8FTE) provide group work at Boronia Pre-release centre for Women, Wooroloo Prison Farm and Bandyup and Hakea Prisons
- one SRN3, one SRN1 and 1.5 PAST staff nurses at Casuarina Prison
- one SRN3, one SRN1 and 1.8 PAST staff nurses at Bandyup Prison
- The co-morbidity position at Eastern Goldfields Regional Prison (EGRP) was abolished in 2008.

The program is supported by two positions located at DCS head office – the Manager Co-Morbidity (Level 7) and the Co-Morbidity Services Coordinator (Level 6) (vacant).

There is no co-morbidity service at either of the two juvenile detention centres; a fulltime psychologist (at Rangeview Remand Centre) and visiting psychiatrist service (at Rangeview and Banksia Hill Detention Centre) provide mental health assessment and treatment.

The separate reporting line for the co-morbidity service is a point of contention in Health Services but does allow the co-morbidity staff to be dedicated to mental health/addiction. A previous model in which mental health staff reported to the Clinical Nurse Manager at each site resulted in a diminution of mental health services.
4.5. Other Clinical Services

4.5.1. Dental health

There are significant deficiencies in the provision of dental services – there are not enough dentists and hours to meet demand. Provision of more dental services would improve the wellbeing of offenders and reduce the reliance on analgesics.

Equipped dental clinics are provided at:

- **Casuarina Prison** – staffed by a dentist and dental nurse from Dental Health Services Western Australia. Patients from Casuarina are treated 3.5 days per week. Patients transported from Karnet and Wooroloo prison farms are treated one day of the week.
- **Hakea Prison** – a dental suite is equipped and staffed by a dentist three days per week.
- **Bandyup Women’s Prison** – dentist attends weekly.
- **Bunbury Regional Prison** – not staffed as yet, but the expectation is it will be staffed by Dental Health Services WA.
- **Albany Regional Prison** - dentist and dental nurse from Dental Health Services provide one session per week. There are around 200 patients on the waiting list, generally only emergencies are seen.
- **Greenough Regional Prison** – one session per week, prioritised on the basis of pain. Extra sessions to be worked in April/May to clear the backlog.

Other health centres must send patients out to a private dentist or public Dental Health Services.

4.5.2. Allied health

There is great variation in the ways that health centres access allied health services, including referral to regional hospitals and Aboriginal medical services.

Some allied health specialists provide weekly in-reach clinics, but generally patients are transported out to services.

4.5.3. Specialist services

As above, the support of specialist services to health centre patients varies greatly. For example, Bunbury Regional Prison has a visiting psychiatrist, surgeon and physician whereas Eastern Goldfields Regional Prison has no visiting specialists.

4.5.4. Education/risk minimisation

The only educational program that is consistently available throughout the State is the HipHop program which provides education on risk factors for BBV and STIs.
4.6. Prison Counselling Service

The Prison Counselling Service (PCS), managed centrally in the Offender Services Directorate, is present in all prisons. Social workers and psychologists are rostered to treat offenders suffering acute and severe psycho-social problems related to their incarceration. In particular, the PCS is called in to manage offenders at risk of self-harm. Health Services clinical staff and the co-morbidity service may also be involved in determining the severity of risk and initiating management in these patients.

The PCS is organisationally quite separate from Health Services, although in the past they have been united. Within most prisons, clinicians of both services liaise and co-operate as they are often treating the same patients. In some prisons however, the two services communicate very little outside the necessary contributions to the assessment of prisoners at high risk of self harm. Even where there is good local co-operation, structural impediments exist such as separate record-keeping.

PCS staff have no involvement in the on-going care of patients with mental illness and their skills in assessment and management of people with mental illness are not available to the ongoing care of offenders with mental illness.

5. ORGANISATIONAL STRUCTURE

The prison-based health centres deliver clinical programs to prisoners. A central office provides programmatic and corporate support to health centre staff and sets standards, policies and consistent clinical procedures.

5.1. Central Office

Health Services’ central office is responsible for:

- clinical and corporate support and leadership
- representing the Service to the wider Department and liaising with key corporate and clinical stakeholders
- ensuring that legislative imperatives are met
- developing policies, clinical programs, clinical protocols, a standard formulary and essential equipment
- maintaining and monitoring clinical standards and practices
- providing corporate support to the health centres by assisting with human resources and finances
- maintaining and developing the electronic medical record (EcHO).

The Service is headed by a medical director. The position is currently filled on an acting basis. Reporting directly to the Director, Health Services are:

- all clinical nurse managers from the health centres
- all doctors
• some senior staff from head office – the Manager Corporate Health Services, the Assistant Director Clinical Governance, Manager Planning, Programs and Policy (currently vacant), a Population Health Physician (0.2FTE – currently vacant) and the Chief Pharmacist.

5.1.1. Pharmacy

A centralised pharmacy, headed by the Chief Pharmacist, is responsible for:

• purchasing of medicines
• blister packing of medicines according to prescriptions
• distribution of medicines to all clinical sites. This includes individualised blister packs and urgent supply packs of medicines to be stored at the centres for use where the prisoner arrives without a blister pack or a new medicine is prescribed.

5.2. Health Centres in Regional Prisons

5.2.1. Organisational overview

All regional health centres are led by a Clinical Nurse Manager (SRN 3). The Clinical Nurse Manager is supported by a medical receptionist and a team of registered and enrolled nurses who deliver the clinical programs; the co-morbidity nurse is generally co-located in the health centre. In all health centres, apart from Bunbury, there are sessional visiting medical services.

5.2.2. Nursing Services

Nursing staff provide an acute care service to offenders through booked clinics, as described in section 4.1. At each health centre a nominated nurse holds a chronic disease or communicable disease ‘portfolio’. Nursing staff are also responsible for the care and cleanliness of the health centre and may spend substantial amounts of time cleaning. They are also responsible for ordering consumables and managing medication stocks.

The Clinical Nurse Manager

The Clinical Nurse Manager (CNM) is expected to work business hours, Monday-Friday, and to spend 40% of his/her time on management and 60% on hands-on clinical work. In practice, the high level of vacancies of nursing staff means that the CNM often participates fully in providing nursing clinics and in the after-hours roster.

The CNM is responsible for ordering stock, ordering and maintaining medications, equipment provision and maintenance, infection control, nurse rosters, paperwork for recruitment of staff, participation in meetings related to the management of the prison, liaison with the Superintendent, clinical standards and compliance with Health Service protocols and policies.

Nursing rosters

Nursing rosters may be of eight, ten or 12 hour shifts. All health centres run
two clinics a day and morning medication rounds; in some regional prisons
the evening medication round is administered by custodial staff as there are
no health staff on duty, but most health centres also administer evening
medications. All health centres also provide comprehensive weekend cover.

On weekdays, the general order of activities is:

- fasting bloods taken
- morning medication round (7am)
- methadone clinic
- morning nurse clinic (9-11.30)
- offender lock-down and security officer takes lunch, so no patient
  access until early afternoon; may be need for a midday medication
  round
- afternoon clinic (1-3.30pm)
- security officers leave clinic
- evening medication round (5pm).

The provision of nursing clinics on weekends varies; weekends are mainly
used to respond to any emergency calls, re-stock the clinic, clean the clinic
and catch up on paperwork.

Pardelup Prison Farm has a nursing service four days per week, provided by
a nurse practitioner.

Table 1: Hours of nursing service at regional prison health centres

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<td>7.30am – 7pm; 7.30pm Tues Wed; 8 hour shifts</td>
<td>7.30am-7pm</td>
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<tr>
<td>Albany</td>
<td>7.00-8.30pm; 8 or 12 hour shifts depending on staffing</td>
<td>7-7.30pm</td>
</tr>
<tr>
<td>Bunbury</td>
<td>7am-7pm, 10 hour shifts</td>
<td>8.30-7pm</td>
</tr>
<tr>
<td>Greenough</td>
<td>7am – 7pm as 8 hour shifts 7-3.30 &amp; 10.30-7pm.</td>
<td>7-5.30pm</td>
</tr>
<tr>
<td>EGRP</td>
<td>7am-3.30pm, occasional late shift 9.30-6pm</td>
<td>As for weekdays</td>
</tr>
<tr>
<td>Broome</td>
<td>7am-5.30pm, 10 hour shifts</td>
<td>7am-5.30pm</td>
</tr>
</tbody>
</table>

*Determined by Local Order 10 issued by the Superintendent

5.2.3. Administrative support

All health centres have a senior medical receptionist (a L2 officer) who
arranges bookings for the clinics, pays accounts and supports the CNM with
human resource and payroll work. Some health centres, such as Bunbury
and Greenough, have a second, part-time receptionist.
5.2.4. Co-morbidity services

Each regional health centre has a co-morbidity nurse, apart from EGRP where this service is provided by the CNM (the co-morbidity nursing position has been abolished).

5.2.5. Medical services

At all regional health centres, with the exception of Bunbury Regional Prison, medical services are provided on a sessional basis by visiting medical officers, contracted from the local Aboriginal health service provider or general practitioner group. In Bunbury, a staff doctor (0.8FTE) provides a clinical service four days per week.

Many contracts for these visiting medical services are out of date and sessional or fee-for-service payments have been increased on an ad-hoc basis, the increase usually being initiated by the provider. At Albany Regional Prison, for example, the payment for a sessional visit from a doctor from the Southern Regional Medical Group costs $1294, with additional charges for travel, administration and any procedures performed. A session may not last any longer than 2.5 hours. A current EGRP contract with the Boulder Medical Centre pays $700 per session.

Table 2: Contracted medical services at regional health centres

<table>
<thead>
<tr>
<th>Prison</th>
<th>Provider of medical services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roebourne</td>
<td>Gemini Medical Centre, one session per week</td>
</tr>
<tr>
<td></td>
<td>Mawarnkarra Health Service Aboriginal Corporation, one session per wk</td>
</tr>
<tr>
<td>Albany</td>
<td>Southern Regional Medical Group, one session per week</td>
</tr>
<tr>
<td>Greenough</td>
<td>Geraldton Regional Aboriginal Medical Service, two sessions per week</td>
</tr>
<tr>
<td>EGRP</td>
<td>Boulder Medical Centre contracted in for one session per week; one Saturday afternoon per month for chronic disease reviews</td>
</tr>
<tr>
<td>Broome</td>
<td>Broome Regional Aboriginal Medical Service, 2-3 sessions per week</td>
</tr>
</tbody>
</table>

* Dr Marissa Gilles from the Geraldton Population Health Unit also provides medical services at Greenough, one session per week.

5.2.6. Dental health

Dental services in regional prisons are minimal.

- Roebourne Health Centre sends patients to the Aboriginal Health Service to attend the visiting dentist – this is intermittent.
- Bunbury Health Centre has built a dental suite and services are to be provided by Dental Health Services WA (of the DoH), although the extent of the service to be provided, and whether any payment is needed, has not been determined as yet.
Albany Health Centre has a fully equipped dental facility with a dentist attending for 2.5 hours per week; there are 120 patients on the waiting list.

Broome Health Centre sends patients to the public dental service outside the prison.

At EGRP, Aboriginal patients attend the visiting dentist at Bega Garnbarringu Health Service which holds a clinic every second month; non-indigenous patients attend the public dental clinic in Boulder and may need to wait 3-4 weeks for an appointment. The planned new prison will have a dental clinic in the health centre.

5.2.7. Other clinical services

The availability of other clinical services varies from site to site, depending on the capacity of the health centre staff to engage local service providers, the availability of local services and affordability.

5.3. Health Centres in the Metropolitan Adult Prisons

5.3.1. Organisational overview

Traditionally, a CNM has been the clinical and administrative leader in metropolitan health centres, as is the case in regional health centres. A short trial at Casuarina and Hakea prisons of appointing a Business Manager (L6) as the health centre manager proved unsuccessful and the health centres have reverted to a CNM lead with dedicated corporate support (a L3 officer).

Hakea Prison Health Centre

This is a large and busy receival prison for men, with daily admission of remand prisoners and daily transfers to other sites. This results in a health centre workload dominated by the assessment and initiation of care of new arrivals, who are often chaotic and may be withdrawing from alcohol and/or drugs. The longer term, sentenced prisoners may be mainstream prisoners or prisoners requiring protection.

Hakea Health Centre has a history dogged by staff disputes and dissatisfaction. An exercise to identify ways to improve services was conducted in 2006, with eleven areas of concern being identified. Seven recommendations were made:

1. Survey to quantify patient demands on the health centre, services actually delivered, streamlining of workflow to maximise productivity.
2. Emphasis on prevention and men’s health.
3. Change to the organisational structure, with a practice manager with a business background to lead the health centre. Clarify roles and responsibilities.
4. Optimise patient access.
5. Optimise appointment system to meet timelines.
6. Recruitment of staff.
7. Education and skill development.

The appointment of a business manager as the health centre manager was tried in Hakea and in 2010 was judged to not be successful. Instead, an officer to provide business support (a L3 officer) for the CNM will be trialled.

Under the leadership of both the CNM and a senior medical officer, Hakea has recently formulated a Business Plan for 2010, the key objectives being:

- To ensure the appointment card system is in place.
- Prepare the health centre to accommodate a muster of 1,200 offenders, by structural realignment and better admission policies.
- Implement standards of care equivalent to community standards.
- Increased staffing to accommodate the planned expansion.
- Performance management for all staff.

Hakea Health Centre provides all clinical programs except for the chronic disease program, which no nurse has agreed to progress in its entirety. An x-ray machine has recently been installed, although there is as yet no agreement about radiographic and radiologic support.

**Casuarina Prison Health Centre**

A maximum-security prison with longer-stay prisoners, the current prisoner population of 750 is due to increase by a further 250 prisoners in October 2010.

Appointment of a L6 Business Manager as the health centre manager was trialled at Casuarina, with a lead clinician belatedly appointed to partner the business manager. It did not work well, with role confusion. The CNM (SRN 4) is now the sole manager of the health centre.

Casuarina Health Centre delivers a full range of clinical programs:

- BBV/STI is allocated as a portfolio to a nurse who is actively re-establishing clinical links with the teaching hospitals.
- The chronic disease portfolio is also actively managed, although the nurse responsible also carries a full acute care workload.
- The co-morbidity program has dedicated addictions and mental health nurses.

There is also an X-ray machine and a radiographer visits twice a week. The machine can take plain films of the chest, abdomen and limbs.

Casuarina Health Centre also has an in-patient facility – the infirmary. This is used for a number of correctional functions (the sex offenders program, CCU) as well as a residence for the frail aged, prisoners who are too ill for the
mainstream prison and some selected prisoners placed into the infirmary by the Superintendent for non-health reasons. The infirmary is staffed by two nurses on a 24 hour basis. Utilisation of the infirmary has been contentious for many years. It is clear that its internal design and equipment shortages make it unsuitable as a health care facility. The need for aged care facilities and a secure in-patient facility should be the subject of planning by the Health-Adult Custodial forum.

As with all metropolitan prison health centres, the infrastructure at Casuarina Health Centre is substandard – there are too few consulting rooms, the security of the consulting rooms is poor and one consulting room does not have a basin for hand washing. The expanded prisoner population, with the necessary increased demand for health services, will be accommodated by moving the current outpatients into the refurbished administration block.

**Bandyup Women’s Prison Health Centre**

Bandyup is a dedicated women’s prison with a current capacity of around 285 offenders. Babies up to one year of age are able to reside in Bandyup with their mother.

The health centre infrastructure is substandard with too few consulting rooms; there is a two bed infirmary. The lack of consulting rooms reduces the clinical services that can be offered and leads to tension between the health centre and PCS.

There is a 24 hour, seven-day-a-week nursing presence, provided by 5FTE, with two positions currently vacant.

A full range of clinical programs is delivered, plus women’s health, antenatal and postnatal care. The programs consist of:

- Co-morbidity: there is little communication between the co-morbidity staff (n=4) and other health centre staff. This, and uncertainty about the hours worked by the co-morbidity staff, has led to poor linkages and poor case management. There are two visiting psychiatrists.
- Chronic disease management – the portfolio is held and actively managed with 70 women identified.
- STIs/BBV – the portfolio is held and screening and treatment provided. About 70% of patients are hepatitis C positive.
- Acute care – much of this is gynaecological; a number of offenders are admitted pregnant and antenatal and postnatal care is provided by health centre staff.

The CNM has recently arranged for the Drug and Alcohol team from King Edward Memorial Hospital to provide in-reach clinics for pregnant women fortnightly, using a room in a demountable building. Antenatal education will be provided on the alternate weeks.
Boronia Pre-release Centre for Women Prison Health Centre

Boronia is a dedicated women’s pre-release centre with a population of about 70. Children up to the age of four years can live fulltime at the centre and children up to age 12 can have overnight stays. As with Bandyup, the female clientele demands specialist nursing and medical skills to manage:

- antenatal and postnatal care of the mother and child
- screen and assess children for illness
- gynaecology.

These are required in addition to the skills necessary to implement the major clinical programs. Two of the three centre nurses have advanced skills in gynaecology and obstetrics and STIs/BBV. Boronia currently has no active chronic disease management program; a planned visiting service from Bandyup has not been possible due to staff shortages at Bandyup.

There is no agreed approach to the role of health centre staff in the assessment and care of children resident with their mothers. Health Services official policy limits the role of health centre staff to the assessment of children prior to entry to the prison and the provision of assistance to mothers and custodial staff in case of illness or emergency. This limited role is not satisfactory to the Superintendent, who seeks greater clinical input into the care of resident children.

Patients attend the health centre for their medications in the morning and at midday. Evening medications are administered by custodial staff.

5.3.2. Nursing Services

Table 3: Hours of nursing service at metropolitan adult prison health centres

<table>
<thead>
<tr>
<th></th>
<th>Mon-Fri</th>
<th>Weekend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hakea</td>
<td>24 hour nursing service, 11.5 hour shifts</td>
<td>7 days per week</td>
</tr>
<tr>
<td>Casuarina</td>
<td>24 hour nursing service, 12 hour shifts</td>
<td>7 days per week</td>
</tr>
<tr>
<td>Bandyup</td>
<td>24 hour nursing service</td>
<td>7 days per week</td>
</tr>
<tr>
<td>Boronia</td>
<td>8 hour service 7.30-3.30</td>
<td>5 days per week</td>
</tr>
</tbody>
</table>

5.3.3. Administrative support

All health centres have one or more medical receptionist.

5.3.4. Co-morbidity Services

Present at all metropolitan adult health centres. At Boronia, the co-morbidity service is restricted to addictions, with a pharmacotherapy program (currently
six patients receive methadone) and regular visits from the addictions service at Hakea which provides one-on-one counselling and group work. Mental health problems are managed by the general nursing and medical services.

5.3.5. Medical Services
Medical staff are assigned to specific health centres and are rotated on an ad hoc basis to cover vacancies at other health centres.
Medical staffing at Hakea and Casuarina is two fulltime primary care doctors at each health centre.
At Bandyup, three staff medical officers work a total of nine sessions per week
At Boronia, there is a visiting staff doctor for one session per week, with planning for additional services second weekly.

5.3.6. Dental Health
Fully equipped dental suites are located in Hakea, Bandyup and Casuarina, however dentists are scarce.

5.3.7. Other Clinical Services
The availability of other clinical services varies from site to site, depending on the energy of the Health Centre staff to engage local service providers, the availability of local services and affordability.

5.4. Health Centres in Metropolitan Juvenile Detention Centres

5.4.1. Organisational Overview
There are two juvenile detention centres for the State - Banksia Hill Detention Centre and Rangeview Remand Centre. Rangeview is a busy remand centre, receiving all male juveniles on remand and holding sentenced female juveniles. Banksia Hill is both a remand centre and a detention centre for sentenced male juveniles.
Each site has a health centre, with common management by the CNM based at Rangeview.

Rangeview Remand Centre
Rangeview has at any one time 60-70 children, most of whom are on remand and whose stay in the Remand Centre is a few days duration. There are also about 20 female children who are sentenced and so have longer stays. About 90% of the population is Aboriginal. Although the average length of stay is short, many of the children return frequently to Rangeview.
The health centre comprises one consulting room, a waiting room, offices and medication room.
All children are assessed on receipt, using the JMR1012. Many new offenders are admitted at night, making 24 hour nursing cover mandatory. All new receivals are assessed by the psychologist, who is able to refer on to a visiting psychiatrist as necessary.

Clinical programs are necessarily limited by the short duration of detention of most children:

- Acute care, including immunisation, wound management, trauma.
- STIs - all boys and girls are screened for STIs, with all girls being treated prospectively and boys being treated if the screen is positive. This in-reach service is provided by Fremantle Hospital.
- BBV screening is offered to all children irrespective of the presence of admitted risk factors. There are currently no children with hepatitis or HIV.
- Chronic disease management – the implementation of management programs for asthma and diabetes has been precluded by lack of space.
- A dentist visits Banksia Hill for one session per week, so only emergencies are treated.
- Addictions and mental health services are provided by visiting clinicians contracted by the detention centre and not linked with the health centre. Negotiations are commencing to begin hearing assessment and treatment by the Speech and Hearing Centre.
- There is little health education, although there has been a positive experience with sex education for girls – lack of staff has prevented this from being continued.

5.4.2. Nursing Services

Rangeview has recently lost staff, and the substantive CNM is on long-term leave. There has been a dispute over the appropriateness of having a staff member on permanent night duty; agency staff have been necessarily used to provide full nursing cover.

Banksia Hill has three nursing staff who provide seven days a week nursing cover. Nursing staff work 12 or 12.5 hours shifts.

Table 4: Hours of nursing service at health centres in metropolitan juvenile Detention Centres

<table>
<thead>
<tr>
<th></th>
<th>Mon-Fri</th>
<th>Weekend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rangeview</td>
<td>24 hour nursing service, 12 hour shifts</td>
<td>7 days per week</td>
</tr>
<tr>
<td>Banksia Hill</td>
<td>12 hours</td>
<td>7 days per week</td>
</tr>
</tbody>
</table>
5.4.3. Administrative support
One medical receptionist is at each site; these staff members are highly valued.

5.4.4. Co-morbidity Services
Nil

5.4.5. Medical Services
Both sites have visiting medical services.
- Rangeview has two visiting doctors (one male, one female) and a visiting psychiatrist from the Bentley Child and Adolescent Unit every two weeks.
- Banksia Hill has a visiting staff doctor.

5.4.6. Dental Health
Dental suite at Banksia Hill, with dental services one session per week.

6. QUALITY AND SAFETY

Many aspects of the quality and safety program in the Health Services are poorly developed. There is no effective monitoring of the quality of services provided, the outcome of services provided on patients or the pro-active assessment of service improvement.

While there are some practical reasons for the failure to develop a comprehensive suite of activities around safety and quality, the lack of such a program means that the Health Service is blind to its impact on its patients.

6.1. Registration, Credentialing and Education

There is a dedicated officer supporting staff in fulfilling the registration and credentialing required to work for Health Services. Health Services, DCS registered with the DoH as an Unmet Area of Need in 2006, which allowed Health Services to extend their recruitment program to include medical graduates not registered in Australia. The support for registration of these doctors recruited overseas has formed a large part of this officer’s duties.

The officer’s activities include:
- support of overseas staff obtaining the appropriate credentials and conditional registration to practice in WA
- ensuring the appropriate credentialing of all employees (staff and contracted employees) prior to their employment (in accordance with DCS and public sector requirements) by Health Services
- checking that the registration of all clinical staff is current.

This officer is also responsible for the continuing professional education of all staff, clinical and non-clinical. However, given that there are no core
competencies for the programs delivered by clinicians, determination of skills held compared to skills needed is not possible. Historically, there seems to have been little support from the DCS Training Academy for the development of health programs and this has hindered the development of a planned educational program.

6.2. Clinical Incident Reporting and Response (CIMS)

CIMS reporting has been a requirement of clinicians in the Health Services for several years, however there is very little compliance by clinical staff and no accepted compilation of reported incidents or use of the information to improve performance.

6.3. Clinical Audit

There are *ad hoc* audits of compliance with policies, activities or outcomes; there is no agreed audit program.

6.4. Research

Research is a major strategy by which the quality of health services and health service provision can be improved. It is only by the results of relevant research that the Health Service can:

- know the prevalence and epidemiology of disease and risk behaviours in the offender population
- know whether the health programs are appropriately targeted
- complete the feedback loops on health interventions
- adjust existing policies and procedures and develop new and appropriate policies and programs.

In addition, research keeps a spirit of inquiry alive in health staff and encourages thoughtful and careful practice – it is no surprise that participants in clinical trials have better outcomes than non-participants, even if the participants received a placebo. It is good for staff morale to be engaged in a meaningful way with research and research provides an avenue for skill development and participation in the broader clinical community.

The Health Service has been involved in a number of research projects, however is not a participant in several major prison health projects initiated by WA-based researchers. Participation in research was identified in:

- the HoPE (Health of Prisoner Evaluation) pilot study by Kraemer, Gately and Kessell at Edith Cowan University
- development of the National Prison Health Indicators by the Australian Institute of Health and Welfare

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• Prof Mike Hobbs study of the mortality and morbidity of prisoners after release from prison⁵

• studies on the health of prisoners at a regional prison and the screening for communicable disease, cited later in this report.

The process for researchers to apply for approval for health-related projects is set out on the HS web site: it involves an initial approval by HS; following HS scrutiny, the proposal is then submitted to the Research and Evaluation Committee of the DCS.

7. A COMPARABLE INTERSTATE OFFENDER HEALTH SERVICE

7.1. Queensland Health Offender Health Services

The Offender Health Service (OHS) was moved from the Department of Corrective Services (QDCS) to the Department of Health in July 2008. The stimulus for this move was the recognition by QDCS, in the wake of the Royal Commission into Dr Patel, that the risks of running a health service without the resources to ensure the competence of clinicians and safety of practice, were high and unmanageable.

The structure of OHS is similar to that in WA, with prisons throughout the State each having a nurse-run health centre with visiting medical staff and a central office to set strategic direction, standards and procedures, plus facilitate corporate issues. OHS has 171 positions and manages health services at 11 sites; there is a Statewide Unit in Brisbane.

OHS is headed by a Medical Director, who has a predominantly strategic role, with operational issues being managed by the Office of the Director of Nursing.

Key differences between OHS and WA Health Services are:

- the lack of overcrowding in Queensland prisons, which facilitates patient isolation as part of the management of communicable diseases
- an existing, secure ten bed in-patient and out-patient facility in the grounds of Princess Alexandria Hospital with clinical staff (nursing and medical) provided by the hospital and security staff by QDCS
- an existing facility for housing the frail aged in the Brisbane area, comprising accommodation for around 30 men, prison carers (under review), occupational therapy and diversional therapy
- a cumbersome medication model that requires nurses at each centre to prepare the medications for each patient prior to the medication rounds purchasing of medications is centralised through Queensland Health;
- no pharmacotherapy program to sentenced male offenders, who are all withdrawn from narcotics once sentenced; women offenders have access to ongoing pharmacotherapy

mental health care provided by visiting nurses, psychologists and psychiatrists from Queensland Health

- the Nurse Unit Manager (equivalent to the Clinical Nurse Manager in WA) has no hands-on clinical role; and

- with the exception of the Nurse Unit Manager (who is Level 3), staffing of the health centres is by Level 2 clinical nurses. A Clinical Nurse Consultant has recently been trialled; this position is responsible for clinical standards and clinical leadership.

The transition has enabled a new look at the management of the health service. Of particular importance has been:

- work to develop a Primary Care Model of Care, with review of the staffing, clinical competencies and programs delivered by the health centre. The Model will describe program objectives, resources, skills and activities, as well as referral pathways. The Primary Care Model of Care encompasses programs in primary health care, chronic disease programs and communicable diseases. This will inform the development of pro-active programs in disease management and prevention

- the Director of OHS reports directly to the Chief Health Officer in Queensland Health. The close linkages with Queensland Health Services allow similar credentialing standards and processes and facilitates integration with mainstream health services

- a new medication model is under consideration

- proactive professional development for nursing staff, with regular meetings of the nurse unit managers.

8. SITUATIONAL ANALYSIS AND RECOMMENDATIONS

Site visits during the consultation identified a number of significant issues that required immediate attention. Health Services has initiated responses to these. Accordingly, these issues, summarised below, have not been included in the recommendations contained in this section of the report.

- The planning for a comprehensive clinical governance framework and compliance with the Critical Incident Monitoring System.

- The updating and development of contracts for the provision of medical services at regional health centres.

- The need to fill staff vacancies, both nursing and medical.

The limited functionality of the electronic medical record (EcHO) and its impact on workflows and workload has, however, been of such magnitude that it is included in the recommendations.
8.1. A Health Service within a Custodial Service

The difficulties of running a health service within a custodial environment have been previously described, by the West Australian Ombudsman in 2000 in the *Report on an investigation into deaths in prisons*, and more recently by the Thematic Review and again in the response by the Department of Health.

My strong impression is that the isolation of the DCS Health Services from the mainstream health services under the auspices of the WA Department of Health will mean that the risks and problems identified in this report will continue to be problematic, despite the best attempts to fix them. These problems are not necessarily related to funding, but to the structural and functional constraints of the organisational arrangements. Specific examples of these constraints are given below.

- HS, DCS attempts to provide the same level of corporate support to the clinicians who work in the state-wide prison health system as that which is provided by a significantly larger corporate support structure in the Department of Health. It is not possible. The corporate support for the HS, DCS is barely adequate, and the negative impact of a corporate structure not attuned to the needs of clinicians working in the public sector is visible daily.

- The clinicians in HS, DCS do not receive salary sacrificing commensurate with that received by clinicians in State hospitals. Parity in salary sacrificing ability would greatly increase the ability of HS, DCS to attract staff.

- In an increasingly complex health environment, with rapid changes in clinical accreditation requirements and potentially new funding models, HS, DCS is increasingly reliant on the Department of Health for advice and advocacy. It is not possible for HS to keep pace with these complexities and therefore the risk of violating legislative and policy requirements is present.

- The risk of communicable disease in overcrowded prisons is the most acute and the most dangerous health risk. The expertise to manage the risks of communicable diseases lies within the Department of Health.

- HS, DCS struggles to develop appropriate clinical governance and policy frameworks and there are as yet no effective feedback and auditing systems in place.

- The chronic under-staffing of the HS, DCS – there is currently a 20+% vacancy rate in nursing staff. Staff recruitment and retention would be improved by the better corporate environment that a dedicated health service can offer. For comparison, the current vacancy in nursing in the State hospitals is just 4%.

- The professional isolation of the staff in HS, DCS from mainstream health services. Few staff have appointments in both HS, DCS and mainstream health services, yet this would be a valuable model, bringing the professionalism and skills required in the broader clinical
environment into the prison. HS, DCS staff would benefit from the professional development and career progression that involvement in a broader health service would bring.

- The need for a health service independent of the custodial service has been recognised and implemented in all Australian states, with the exception of Victoria which has a hybrid model. The organisational structure that locates the Health Service within DCS in Western Australia creates specific problems in the provision of health care, based on the significantly different philosophies of these two groups. The following examples illustrate the practical implications of these philosophical differences:
  - The security of prisons and offenders is of prime importance to DCS while the health and well-being of offenders is of prime importance to Health Services, yet the decision-making of staff in Health Services is strongly influenced by security and cost issues.
  - The empowerment and education essential for behaviour change and health promotion may not be supported by custodial services, as in the provision of bleach to assist in cleaning injecting equipment.
  - Adequate infrastructure of the health centres and access to offenders is essential to the effective functioning of Health Services, but this may not be a cost or change to routine that DCS is prepared to make.

While Health Services is situated within a custodial organisation, the provision of safe and cost-effective health care may be unduly influenced by the needs of the custodial environment.

The case for change in the organisational arrangement of WA offender health services remains compelling.

**8.2. Strategic Direction and Clinical Service Delivery Model**

Despite the operational difficulties described above, the strategic direction of clinical programs and the structure of the workforce are appropriate for a primary care service to this population. Of particular note are the following positive aspects of the Health Service:

- Clinical services are both reactive to acute needs and proactive in identifying, diagnosing and treating illnesses; this proactive approach to disease identification and management is a strong feature of the clinical service.
- The concept of outsourcing health care for offenders has been raised. While visiting nursing and medical personnel could provide a range of health services (if outside health service providers could be found for all prisons) it is unlikely that visiting health staff could fulfil the responsibilities of a prison health service. Core clinical services must be provided by staff located at the prison and dedicated to the best
outcomes for offenders, supplemented by in-reach programs and clinical care provided by local organisations and health professionals.

- A centralised model of management with the opportunity for local flexibility is essential for maintaining consistent clinical approaches and clinical governance.
- The centralised booking service for clinical appointments in the metropolitan area is well thought through and should be continued.
- The separation in management and administration of the Health Service from the prisons themselves enables Health Services to deliver health care as freely as possible from custodial influence and to optimise the management of health risks through having control of the staffing and functions of the Service.
- The centralised pharmacy is excellent, relieving much of the tedium of medication dispensing from nursing staff and so reducing the risk of medication errors.
- Restriction of the range of prescribed medications, in particular psychoactive medications, to reduce the risk of trafficking, bullying and injecting drug use, is sensible and valuable. While doctors occasionally object to such controls on their prescribing, and are under pressure from patients seeking psychoactive drugs, the appropriate public health response is to reduce the supply of medicines which may inadvertently increase the health risk to the patient.
- The electronic medical (EcHO) record is conceptually good, but functionally poor and needs urgent attention.
- The methadone program throughout all prisons runs smoothly and is essential for reducing use of opiates within prison and increasing the safety of newly released offenders who use opiates.

8.3. Links to Key Partners

8.3.1. Corrective Services

The most important partners in the delivery of services by Health Services are the Deputy Commissioner for Adult Custodial and the Deputy Commissioner for Community and Youth Justice. The planning of system-wide change and resolution of contentious issues at this level would relieve much of the tension felt by clinical staff in negotiating issues with their own Superintendent.

- Clarification over the roles and responsibilities of Health Services and Corrective Services staff needs to be determined and agreed at a high level.
- System capacity issues, in particular the need for a dedicated in-patient facility and facility for the care of the frail and aged. These facilities would resolve the pressure to provide care in the infirmary, which is not fit for use as a health care ward.
- The perceived failure of the security transport service to meet its booked obligations, resulting in patients not attending specialist
appointments outside the prison.

- Issues that are jointly the responsibility of the Health Service and Adult Custodial that have high cost or high impact, such as the need for an effective patient transport vehicle at Casuarina Prison.
- Smaller but endlessly troublesome issues, such as the provision of Panadol in prisons. Adequate infrastructure to facilitate a telephone appointment system could also be resolved, contributing to a more standardised approach across the State.
- The provision of professional cleaners for health centres which should not be cleaned by offenders or nursing staff, although nursing staff are responsible for the cleanliness and preparedness of equipment.

**Recommendation 1**

Formal and regular meetings between the Deputy Commissioner Adult Custodial, the Deputy Commissioner Community and Youth Justice, the Deputy Commissioner OMPD and senior staff are convened, with agreed Terms of Reference and minutes. Health Services to provide executive support for this forum. Its key function is to determine roles and responsibilities of each Service, and to resolve contentious issues.

8.3.2. **Department of Health**

The need for close links with program areas and professional bodies is essential. The Director General of Health is waiting to consider this report before making any decisions about formal linkages.

In the meantime, linkages can be formed with the Office of the Chief Nurse, forensic mental health services and tertiary services on an as-needed basis.

**Recommendation 2**

Explore the ways in which effective linkages between HS, DCS and the Department of Health can be formed

8.4. **Managing the Risks of Incarceration**

8.4.1. **Communicable Disease**

The most significant health risk of incarceration is that of communicable disease. The overcrowding of prisons, the prevalence of high risk behaviours, the lack of access to safe injecting equipment and the inability to effectively isolate infected prisoners all contribute to the risk of an epidemic of communicable disease. The risk is to prisoners, prison staff and the broader
community, and the risks come from air-borne infections (influenza, chickenpox, measles), blood-borne infections (hepatitis C, HIV) faecal-oral infections (hepatitis A, norovirus) and infections transmitted by close physical contact (meningococcal meningitis, infectious mononucleosis).

Health Services, DCS has been mindful of this risk and has proactively established programs in infection control, STI and blood borne virus identification, management and prevention. The Infection Control program aims to maximise vaccination, screen children entering detention for communicable disease, plan the response to an influenza pandemic, ensure the cleanliness of health centres, identify and treat communicable diseases, identify notifiable diseases and conduct contact tracing. For some aspects of the communicable disease program, especially those that are outside the designated portfolios of STI/BBV control, adherence and interest of clinical staff is suboptimal. Several recent studies have confirmed that screening for STIs and BBVs is sub-optimal and that vaccination coverage for influenza and pneumococcal disease is low.67

Communicable disease remains the most significant and immediate health risk of incarceration. Health Services and DCS broadly will be held accountable should a potentially-preventable epidemic occur and be poorly managed.

**Recommendation 3**

Health Services policies and actions for infection control and the control of infectious diseases be reviewed annually by an expert in infection control, and their advice be implemented.

### 8.4.2. Acute Response to Incarceration

Mental illness is present prior to incarceration in a relatively high proportion of offenders. A 2005 study in Western Australia found that 18% of prisoners had been in contact with a mental health service in the five years prior to imprisonment. The prevalence of severe mental illness in prisons is 15%-20%, compared to 3% in the general adult population. In addition, there are negative mental health effects of prison circumstances alone - anger, guilt, deprivation of freedom, anxiety, aggression and boredom.8

The PCS responds to these acute risks. The co-morbidity service and CNM may also be involved in decisions about the management of offenders at risk of self harm. Ongoing care for mental health problems falls to the co-morbidity service.

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There are, in most sites, close linkages between PCS and the Health Service staff in managing clients, however there is no common clinical record and reporting lines are separate. The same patient may receive parallel services from both clinical groups.

Closer integration of the services would benefit both services, expanding the range of clinical skills utilised by staff in the PCS and enhancing the range of therapeutic options available to patients with mental illness.

**Recommendation 4**

The potential benefits in service provision of closer integration between Prison Counselling Services and Health Services should be explored.

### 8.5. Clinical Programs

The clinical programs are appropriately focused; however there is scope for improvement.

#### 8.5.1. Model of Care

The model of care of the chronic disease and communicable disease programs, in which a clinical nurse is appointed as portfolio holder, is supported. The alternative approach, in which all members of the clinical team are skilled in all program areas, has been proposed, but is not felt to be the best model of care. It was the failure of this generic approach that led to the establishment of the portfolio model and the value of having a champion of the program in each health centre in terms of skills and service delivery has been shown.

**Recommendation 5**

Liaise with the CNMs at those health centres without an active chronic disease management program to appoint and train a nurse with specific portfolio responsibility.

#### 8.5.2. Scope of Practice, Service Standards and Clinical Competencies

While the proactive programs in chronic disease, STI and BBV management have gone some way towards identifying their service provision objectives and activities, this has not happened for the acute care program. No program area has specified the clinical competencies required for program delivery.

The acute care program has grown historically, with no recent review of the presenting conditions, services provided or outcomes, or an agreed vision of
the scope of practice at each health centre. The belief of some staff that an expanded range of diagnostic and treatment service could and should be provided by the larger prison centres (Hakea and Casuarina), should be explored and critically examined.

**Recommendation 6**

A review is undertaken of the existing service provision by nurses and doctors working in acute care, documenting the conditions treated, management strategies and outcomes; this will enable the provision of the information needed to develop an agreed scope of practice for acute health care, treatment protocols, resource requirements and the clinical competencies of practitioners.

**Recommendation 7**

All clinical programs to describe and document:

- the service purpose and objectives
- tasks and responsibilities of each service provider
- client group
- resources required
- clinical competencies of the professionals involved in the program
- service standards, and key performance indicators.

Annual reporting against agreed KPIs to identify gaps in service provision.

8.5.3. **A women’s Health Program**

The Thematic Review in 2006 recommended that ‘A comprehensive women’s health policy, taking in the needs of women in regional prisons as well as those at Bandyup and Boronia should be developed and implemented.’

The strategic direction for women’s health was articulated in a document titled *Strategic Directions – Health Care for Women and Girls 2008-2012*. This document identifies three goals and the strategies needed to achieve these goals:

- Deliver improvements in the health and wellbeing of women and girl patients that are sustainable after release from custody.
- Deliver appropriate community standard primary, preventive and alternative health care choices within a holistic service delivery model.
- Promote understanding of the situation and needs of women and girls
who have contact with the criminal justice system, along with the needs and risks for their children and families.

Separate Health Service policies exist on pregnancy and pregnancy termination.

A policy titled *Child Health and Health Care of Resident Infants, Children* sets out the responsibilities of health centre staff in the assessment of resident children and their ongoing care. Briefly, this policy limits the involvement of health centre staff in the care of children to pre-admission assessment, response to emergencies and facilitation of access to specialist child health services. In practice, health centre staff find it impossible to not assess a sick child brought to them by a distressed mother resident in the prison, and often supply medications for the care of children and infants with minor illnesses. The legal position of staff in these situations is unclear.

While the energy and expertise of staff at Bandyup and Boronia has ensured that women have access to essential screening, gynaecological and obstetric care, this is not formalised as a clinical procedure and does not extend to regional prisons with female offenders, and is practiced to a limited extent in the juvenile detention and remand centres.

**Recommendation 8**

1. The *Strategic Directions – Health Care for Women and Girls 2008-2012* be implemented.

2. The policy *Child Health and Health Care of Resident Infants, Children* be reviewed, and the legal implications of the Health Service treating a non-offender be clarified.

**8.5.4. Aboriginal Health**

It has long been a criticism of the Health Service, DCS that there are no specific programs for Aboriginal health. I met only one Aboriginal clinician employed in Health Services. However these skills and programs may be available in the community. Aboriginal health services often have Aboriginal health workers who provide health education, social support and re-integration of offenders with the community.

Although a precise set of clinical and prevention programs suitable for Aboriginal people has not been delineated, it would seem at first glance to encompass:

- the proactive identification of Aboriginal people and invitation to health review
- the provision of gender-appropriate clinical staff
- screening for communicable disease, diabetes, cardiac disease and
renal disease

- regular recall for review
- involvement of the local Aboriginal health services in the care and education of Aboriginal people.

**Recommendation 9**

1. Health Services actively identifies agencies that can provide support for indigenous offenders and investigate their role in the provision of Aboriginal-specific services and culturally appropriate supports to existing clinical programs.

2. In partnership with community-based Aboriginal health services, develop and trial an evidence-based indigenous health program.

**8.5.4.1. Health Services for the Juvenile Detention and Remand Centres**

Young offenders and children on remand are a population with special needs, requiring the same range of services as adults, delivered in an age-appropriate way. The prevalence of alcohol and drug abuse in this population is high. The *Young People in Custody Health Survey 2003* reported a strong correlation between alcohol and offending behaviour, with 60% being affected by drugs or alcohol at the time of the offence, 69% of offenders reporting harmful levels of use of alcohol plus smoking and 98% having used illicit drugs.

In 2003 the WHO released a Consensus Statement titled *Promoting the Health of Young People in Custody*, setting out the eight principles for achieving the following objectives:

- To promote the physical, mental and social aspects of the health of young people in custody.
- To help prevent the deterioration of young people’s health during or because of custody.
- To help young people in custody develop the knowledge, skills and confidence they need to enable them to adopt healthier behaviours that they can take back into the community with them.

HS does not have specific clinical programs for youths and does not seem to deliver the adult-oriented programs in an age-appropriate way. The greater role of in-reach addiction and mental health services for youths makes integration of an individuals’ care more difficult.

**Recommendation 10**
The clinical programs provided by HS to youths need to be reviewed to ensure they are comprehensive and age-appropriate.

8.5.5. **Review of the Asthma Chronic Disease Program**

The prevalence of asthma in the offender population is said to be around 30%; this seems amazing for a disease that is not related to socio-economic disadvantage and it is most likely an artefact of reporting methods. However, smoking-related diseases such as chronic obstructive pulmonary disease (COPD), chronic bronchitis and emphysema are certain to be common, as are lung diseases associated with infection, such as bronchiectasis.

**Recommendation 11**

The Asthma Management Plan be expanded into a lung health care plan.

8.5.6. **Smoking Cessation**

A 2008 policy is current for Nicotine Replacement Therapy (NRT). This policy stipulates that all offenders deemed to be current smokers at the initial health assessment will be offered NRT as a 12 week step-down course. Prior to commencement, the patient must have received a brief intervention by nursing staff and the medical officer must have assessed the patient for contraindications.

In practice, there is a piecemeal approach to smoking cessation programs. Some staff have been trained in the Freshstart Program run by the Cancer Council, but there is no consistent training and program provision across the Service. Anecdotal reports are that offenders take NRT only when they run out of money to purchase cigarettes, and that NRT patches are used as chips in gambling.

A consistent approach is required.

**Recommendation 12**

Review the current smoking cessation policy and activities and plan an effective program that supports making prisons smoke-free.

8.5.7. **Mental Health/addictions**

It is hard to get a clear understanding of the activities of staff of the co-morbidity program. The co-morbidity program is a pragmatic approach to the provision of care for people with mental health and/or addictions, and so must have clear treatment approaches for a range of mental illnesses and addictions, and clear guidelines on referral to specialist services.

There are no clear entry criteria for patients, no clear clinical protocols for
patient assessment or management for either mental health or addictions and no established competencies for the staff of the program. Previous clinical assessment and treatment pathways for addiction services need to be urgently reviewed and updated. There does not seem to be a consistent approach to patients with addictions or mental illness across the Service.

Program staff mentioned that they lacked professional development and professional support, and were reliant on their own initiatives for training.

**Recommendation 13**

1. The Manager, Co-morbidity Program engage the assistance of the Drug and Alcohol Office and forensic Mental Health Services to develop a set of evidence-based program protocols, clinical pathways and staff competencies.

2. In-reach specialist forensic mental health services which strengthen the co-morbidity program and expand the range of therapeutic options be developed.

3. A specialist steering group for the co-morbidity program be convened to assist the Manager in supporting staff development and monitoring clinical practice and patient outcomes.

4. Consideration should be given to filling the vacant co-ordinator position, to allow the Manager to focus on strategic and programatic issues.

The landscape of mental health services in WA is changing with the formation of the Mental Health Commission and its intention to purchase mental health services. The implications of this change on the provision of mental health/addictions services to the prisons are unclear.

Health Services should engage early with the Commission to identify any potential to enhance services.

**Recommendation 14**

Health Services to meet with the Commissioner for Mental Health to discuss the implications of the new Commission on the provision of services to offenders.
The value of changing the reporting lines of the co-morbidity program to be to the CNM at each site has been raised and considered. Tensions within some Health Centres exist over use of scarce consulting rooms, lack of communication between the teams and the ability of co-morbidity staff to not assist with the acute care workload when the pressure is on. Alternatively, in many centres, the liaison is positive; co-morbidity staff assist acute care staff when possible.

Overall, it is hard to see what value would be added by a change to the reporting lines, especially when the Mental Health Commission may change the way services are provided.

8.5.8. Dental Health

There is inadequate provision of dental services, with offenders suffering pain while they wait for dental care. The Corrections Health Program (ACT Health) estimates that one day of dentist time per week is required for each 150 offenders – using this benchmark, HS, DCS require 33 days of dental time per week.

Dentists are expensive to hire. However useful relationships exist with Dental Health Services WA. These should be expanded and ways sought to obtain more dental time.

Recommendation 15

Re-open a dialogue with WA Dental Health Services to explore ways of obtaining more dental time in the Health Centres.

8.6. Workforce and Structure

8.6.1. A State-wide Clinical Services Unit

The backbone of the primary care service is a nursing service, with varying amounts of medical and allied health support. With the abolition of the Director of Nursing (DON) several years ago, to create the position of Assistant Director Clinical Governance, the leadership and professional direction for nursing has been lost. The direct unwanted results have been:

- a default of the essential duties of the DON to the AD Clinical Governance position, with the inevitable loss of any effective clinical governance
- loss of a strategic approach to the development of the nursing workforce
- no planned professional development and training
- loss of standards for nursing
- no person in head office responsible for Health Centre nursing support.

For example, the 2007 report by Professor Chiarella and recommendations on nursing practice and professional development does not appear to have been implemented. It should be reviewed and relevant recommendations progressed.

Leadership and operational support for medical officers in Health Services is currently provided by the Director, Health Services and by various medical officers within the Service who make individual contributions to professional development, peer review and Committee leadership. The responsibility for operational support should be delegated directly to the Statewide Clinical Services Unit, with the Director, Health Services retaining responsibility for leadership and professional support for medical officers.

The Manager, Clinical Services should have a close liaison with the Chief Nursing Officer of the Department of Health and should attend the State Executive Forum run by the Chief Nurse.

**Recommendation 16**

The position of Manager, Clinical Services be established and filled by a senior nurse with substantial experience in managing nursing services in a complex environment. This position will be responsible for the operational aspects of clinical service delivery and for leadership and support for clinical staff.

The Manager be supported by a Co-ordinator of Clinical Services. Together these positions would ensure that the Health Centres staff have support for:

- attracting and retaining clinical staff
- developing a plan for nursing staff career progression
- professional development and training for nurses and medical staff
- program delivery and evaluation
- the managerial role of Clinical Nurse Managers and their continued involvement in health centre decisions and changes
- communicating with health centre staff and ensuring their input into decisions that affect them.

**Recommendation 17**

The Manager, Clinical Services be supported by a Coordinator of Nursing Services.
Clinical Governance

The Assistant Director, Clinical Governance, is responsible for the development and implementation of clinical governance in the Health Service. The Clinical Governance staff should be part of the Clinical Services Unit and report to the Manager, Clinical Services Unit. This will ensure integration of clinical governance within all clinical operations. The existing positions of Program Manager, Clinical Credentialing and Performance (L6) and Quality Improvement Coordinator (L6) also be moved into the Clinical Services Unit.

Staff professional development is poor. The Health Services has a responsibility for maintaining and developing the skills of its staff, to ensure that programs are delivered efficiently and that staff are retained. A planned program of staff development is required, and each staff member should have a staff development plan tailored to their skill level, job requirements and career aspirations within the Health Service.

Recommendation 18

1. Clinical Governance be part of the responsibility of the Clinical Services Unit.

2. Each Health Service staff member be encouraged to submit a professional development plan, which will guide the training offered and support given to professional development.

Nurse Practitioners

Nurse practitioners have the potential to add value to various clinical programs in Health Services. In particular:

- specific clinical programs with specialised diagnostic and care needs, such as the blood borne virus program, mental health and clinical nurse managers
- primary care in remote locations with limited medical support
- infection control
- the assessment and initial care of newly received remand prisoners.

Nurse practitioner positions also provide a career path for registered nurses. The Office of the Chief Nurse in the Department of Health has carriage of the policy and implementation of nurse practitioner training and credentialing for Western Australia.

Scholarships have been made available for registered nurses in HS, DCS to undertake training as nurse practitioners. Several nurses have completed their training, and are seeking endorsement of Health Services as an organisation which employs nurse practitioners. Unfortunately this important initiative appears to have stalled.
The policies, support and opportunities for nurse practitioners are changing rapidly and the Chief Nurse of the Department of Health should be closely involved in the development of the roles and training for nurse practitioners within Health Services.

**Recommendation 19**

The Manager, Clinical Services, in partnership with relevant stakeholders, develop a strategy for the training and employment of nurse practitioners.

**Nursing rosters**

There is variation across the Health Service in the hours worked by health centre nursing staff and the support provided by the Superintendent. At one end of the spectrum is EGRP, where the nursing staff work 8 hour shifts and afternoon medications are administered by custodial staff; at the other end is the requirement at Roebourne that the nursing staff are on site until lock-up, and later on the days the inter-prison transfers occur.

In many health centres, the nurse rosters are such that the overlap of the morning shift (7am-3pm, or thereabouts) and the afternoon shift (11am-7pm, or thereabouts) is between late morning and early afternoon, when most prisons preclude access to patients due to the lock-down.

Nursing Awards in WA allow for most shifts to be worked, provided these are by agreement between the nurses and management. In many cases, 12 hours shifts are both convenient to nurses and are an efficient deployment of the workforce, given the restrictions to patient access imposed by prison regimes.

**Recommendation 20**

1. The Clinical Services Unit conduct a review of nursing rosters, to identify the most cost efficient and acceptable model of nurse rosters for each site.
2. HS, DCS and custodial services agree on the most efficient use of nursing time, to reduce the resources used with nurses waiting for ‘something to happen’.
8.6.2. Director, Health Services

With the re-establishment of the Clinical Services Unit, a significant operational load should be transferred from the position of Director, Health Services.

Whether or not the Director’s position should be a medical position has been strongly debated within the Service. There are pros and cons to each option:

Factors that favour a medical Director are:

- The Service is primarily a clinical service and should be led by a clinician who can provide leadership and advice on clinical issues; a non-medical Director could not provide clinical leadership.
- Improved corporate support can be provided by an enhanced business area.
- A medical Director can provide leadership to the clinical and non-clinical staff and programs.

Factors that favour a non-medical Director are:

- Much of the role of Health Office is one of corporate support, and it is the failure of corporate support, in particular human resources, which has caused much of the recent dysfunction.
- A non-medical Director is cheaper than a medical Director, however medical expertise and leadership is still required, so a Principal Medical Officer would still be required, negating any cost savings.
- A non-medical Director frees up a doctor to concentrate on medical issues.

Health Services is a clinical service, and in the ideal world would be led by a clinician who has administrative skills and who can conceive a Service that provides more than reactive clinical care. The recent contribution of a higher level Business Manager in thinking creatively about solving corporate problems is also acknowledged.

On balance, I would favour a medical practitioner as Director, Health Services, who has higher level Business Manager support.

Recommendation 21

The Director, Health Services should continue to be a Medical Director.

8.6.3. Public Health program leadership

Public health approaches and programs are central to the ability of the Health Service to deliver (1) protection of the health of offenders and (2) health improvement.

Existing public health programs in communicable disease, chronic disease control, research and mental health are currently reporting to the Clinical
Governance position, while the part-time position for a Public Health Physician is vacant.

The position of Public Health Physician should be increased from 0.2FTE to 0.5FTE. The attempt to obtain useful public health support, in particular the management of patients with communicable disease such as HIV and STIs, with a very part-time position (0.2FTE), has been found not to work. Programs with a strong public health approach, including the communicable disease and chronic disease management programs, and research, should be aligned to report to the Public Health Physician, who in turn reports to the Director, Health Services.

**Recommendation 22**

The Public Health Physician position be increased to 0.5FTE and filled.

Existing and new public health programs such as the women’s health, communicable diseases and chronic diseases programs should report to the Public Health Physician.

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**8.6.4. Corporate Support**

**Human Resource Management**

The most tangible deficiency of the corporate service provided by the central office is the lack of effective management of staff and support of the CNMs in human resource management.

Hallmarks of the Service with respect to human resource management are:

- vacancies in nursing and medical positions
- lack of understanding by CNMs of public sector rules around positions and position numbers, such that the increasing part-time nature of nursing staff has reduced hours of the existing FTE with no flexibility to create new FTE from the unused but funded capacity
- lack of flexibility in position criteria, limiting appointments even if suitable.

**Recommendation 23**

A professional review be undertaken of the HR practices in Health Services and guidance be provided to clinical nurse managers on adapting approaches to facilitate staff appointment within public sector management policies.
8.6.5. Health Centre Leadership

The bulk of the clinical work in health centres is performed by nursing staff, with either resident or visiting medical staff providing clinical support and a state wide out-of-hours consultation service. Nurses are the first clinical contact for patients and they provide care, triage and referral and see patients daily when administering medications.

The position of CNM has traditionally been the head of each health centre and this model has now been re-established in all metropolitan and regional health centres. Continuation of the CNM as the health centre manager and lead is strongly supported.

The potential of a co-director model (medical and nursing) in the two large health centres of Hakea and Casuarina has been canvassed. Such a model, with joint energy and leadership, would potentially provide a more strategic approach to the management of the health centre, clinical practice and clinical governance. However it would also draw very scarce medical resources away from clinical work.

While acknowledging the benefits of engaging medical officers in the strategic operations of the health centre, medical officers are currently too scarce to be asked to set aside regular time for this function. The model should be reassessed once the Clinical Services Unit has been established and better support provided from central office to health centre managers and, when business support at the health centre has been provided.

Recommendation 24

The Clinical Nurse Manager continue as the head of the health centre; the potential for medical and nursing co-directors at Hakea and Casuarina be reassessed when staffing levels permit.

8.6.6. Medication Management

The centralised pharmacy’s ability to provide a large proportion of medications blister packaged for each patient is a substantial achievement. Complaints about this service were infrequent and generally related to lack of knowledge about how to rapidly access medications not in the urgent supply packs.

The most consistent frustrations experienced by staff were reported as:

- the difficulty of administering medications under time pressure, particularly at Casuarina and Hakea
- time taken checking and ordering medications and keeping registers of s8 and s4 (restricted) medicines
- patients transferred without sufficient medications to last until the next pharmacy supply to that receiving prison
- some errors in blister packs, and delays in responsiveness to changes in medications.
Medication assistants have been trialled at Casuarina and Hakea with limited success. Concurrently, Bandyup has a L2 pharmacy technician who manages the medications, orders stock, ensures scripts are faxed, maintains the Registers and assists in medication administration. No problems with medications were reported from Bandyup.

It would appear that Hakea and Casuarina would benefit from also having a pharmacy technician, or an enrolled nurse, who can take these responsibilities off the primary care nurses.

**Recommendation 25**

Pharmacy technicians are appointed at both Hakea and Casuarina health centres to take responsibility for all medication management – ordering stocks, storage, monitoring and assisting with administration.

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**8.7. The Electronic Medical Record (EcHO)**

The deficiencies of the electronic medical record are well known and are causing frustration, delays, reduced productivity and possibly errors. The electronic medical record was also to be the vehicle through which data on Health Service activity and patient outcomes could be reviewed, but this functionality has not been achieved. It would not now be possible to return to paper-based records so the system must be either improved or replaced.

**Recommendation 26**

Health Services must, as a priority, assess whether EcHO can be enhanced to the level of functionality envisaged and, if so, progress its development.

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**8.8. Research**

HS needs to provide clear and positive indications that health-related research is encouraged and will be actively supported. The current policy in which proposals are initially assessed by HS for their contribution to health care and practicality before wider distribution appears to be appropriate. Continued representation of HS on the Research and Evaluation Committee of DCS is of benefit in supporting the merits of health-related projects.

While HS may not have the funds to support internal or external researchers, HS can benefit from engagement with projects funded by other agencies and can, in the future, partner researchers in grant proposals.
Recommendation 27

1. Health Services continues to support national and state health surveys of WA prisoners.

2. Health Services liaises with key prison health researchers in WA to develop a strategic research plan, which could incorporate studies that address:
   - the ongoing identification and quantification of health needs
   - interventional research
   - innovative models of care and care delivery.

9. CONCLUSION

Finally, I would acknowledge the difficulties of providing a health service in a custodial environment and pay tribute to those who work in this environment and those who work to improve the quality and range of services. During my site visits I met many clinical and administrative staff who were passionate about their work and the quality of the service they provided.

If we can overcome some of the key service gaps, both corporate and clinical, provide leadership and professional support and a stable work environment, we will improve staff satisfaction and the quality of our service to offenders and prisons.