

## 15 PRISON HEALTH

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Effective interventions at the interface between the criminal justice system and health systems have the potential to make a significant impact on hauora Māori. Any discussion of this interface must acknowledge as a starting point the colonial origins of the New Zealand criminal justice system and correctional systems. These systems have been transported to and transplanted in Aotearoa/New Zealand, with a British methodology for punishment and rehabilitation of individuals convicted of offences deemed significant and serious. Into this framework, kaupapa Māori initiatives have been added in an effort to bring elements of Māori methodology into the institutional arrangements. Despite these concessions, the courts and prisons represent important mechanisms reinforcing the dominant culture's institutional power, with significant potential to alter the life course of those managed through their processes. The topic of prisoner health and imprisonment is included in *Hauora: Māori standards of health IV* to keep this health setting visible and to highlight the peculiarly stigmatising and potentially harmful outcome that can occur for Māori as a result of systemic failures in health and other sectors.

New Zealand has a high rate of incarceration (189/100,000 in 2006) compared to other OECD countries and Māori experience imprisonment at an alarmingly high rate (568 per 100,000 for Māori compared to 98 per 100,000 for non-Māori in 2006) (OECD 2007; Ministry of Justice 2007).

Table 15.1, based on Department of Corrections data for sentenced prisoners, demonstrates that Māori imprisonment rates, adjusted for population size and age structure, are more than five and seven times the rates of non-Māori for males and females respectively. A marked disparity is also seen in remand rates with Māori eleven times more likely to be remanded in custody than Europeans awaiting Court appearance or sentence (Ministry of Justice 2007).

**Table 15.1: Sentenced prisoners 2003 by sex, total numbers and age-standardised rates per 1,000 population**

Sex	Māori		Non-Māori		Rate ratio
	Number	Rate per 1,000	Number	Rate per 1,000	
Males	2,335	11.86	2,498	2.14	5.54
Females	148	0.70	114	0.10	7.20

Rates age-standardised to 2003 total Māori population aged 14 years and over.

Prison inmates not only lose their freedom but also lose the ability to influence matters affecting their health, including sanitation, diet, level and type of physical activity, social environment, communicable disease exposure, and health care. Internationally and in New Zealand, prison health systems are increasingly under scrutiny as formal evidence of the high levels of morbidity, disability, and mortality in inmate populations is recognised (Simpson et al 1999; Sattar 2001; Wobeser et al 2002; Correctional Services Canada 2004; Ministry of Health 2006; Møller et al 2007).

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The state has a 'duty of care' and inmates have a right to health care 'equivalent' to that available outside prison (New Zealand Corrections Act 2004). As Māori make up a high percentage of the prison population, issues of access and quality of care within prison health systems are of particular interest. Current services are of variable quality, often depending more on local relationships with providers or the competence and motivation of particular health professionals than consistent systems supporting professionals to deliver high quality care in this specialised setting. Facilities, access, privacy, information systems, professional standards and clinical best practice, screening and surveillance, mental health, alcohol and drug treatment, public health and primary care are all areas requiring further development to meet a standard of 'equivalence' with community health services.

Prisons can act as a reservoir of communicable disease, affecting not only inmates and staff but the wider community. A tuberculosis outbreak associated with Rangipo Prison was linked to seven prison-associated cases and affected at least 54 in the non-prison community, with 86% of those affected Māori (De Zoysa et al 2001). Inmates and prison staff are entitled to expect protection from infectious disease, and prison-acquired communicable disease represents a significant potential compensation risk.

The prison environment itself is harsh, physically and psychologically, and the negative health effects are beginning to be documented in a more systematic way than previously. Incarceration may reduce life expectancy. The effect on amenable mortality of restricted access to adequate nutrition and physical activity, (the 'enforced idleness' described by the Office of the Ombudsmen) (Ministry of Justice 2005), additional exposures to carcinogens and infectious agents, and barriers to health care interventions that are shown to improve outcomes may compound in a way that can be measured at a population level. Our ability to quantify the effects for individuals on cardiovascular risk, for example, is rapidly becoming more sophisticated.

Imprisonment removes freedom but at what point do we acknowledge and quantify the additional risks of incarceration for Māori by imposing conditions that are known, in a community context, to increase the risk of premature morbidity and mortality?

Prisons offer the opportunity, on the other hand, to intervene in ways that reduce barriers to health care and ensure excellence in the care offered (Møller et al 2007). There has been considerable work between the Ministry of Health and Department of Corrections, since a Memorandum of Understanding was signed in 2003, to improve health services and information about the health of prisoners. The least we should aim for is a high standard of prison health service, a population level surveillance system of the health of prisoners and informed responses to the results, specialised and supported health professionals, and an optimum prison building and programme design, to minimise the harm of incarceration.

A public health approach to Māori imprisonment, however, would concentrate on 'upstream' measures to reduce the high rate of criminal conviction and imprisonment of Māori. Income inequality, educational system failure, lack of early and intensive interventions to address the needs of rangatahi 'at risk' or early in their contact with the criminal justice system require a serious shift in resource allocation. The current frameworks within the Department of Corrections focus on 'criminogenic' factors for individuals, with limited acknowledgment of structural, environmental, or social

determinants of crime. Nor is there consistent support for early intervention across the health and criminal justice systems.

Intergenerational deprivation, compounded by imprisonment and alienation, is unlikely to produce improved outcomes. There is ample evidence of the failure of imprisonment in reducing recidivism and good evidence for alternative approaches for people with underlying drug and alcohol issues and those involved in less serious crime (Ministry of Health 2007). Although prison overcrowding and the burgeoning associated costs, compensation claims by prisoners, and the Ombudsmen's Investigation of the Department of Corrections have prompted a policy re-think, barriers to change in the Health and Corrections systems and relatively uninformed public debate allow more young Māori to be processed into prisons every day.

The National Health Committee's Public Health Advisory Committee has recently released their document supporting Health Impact Assessment as "a formal process that aims to ensure public policies, programmes and plans enhance the potentially beneficial effects on health and wellbeing and reduce or mitigate the potential harm with innovative solutions" (National Advisory Committee on Health and Disability 2007, p.2). The case for Health Impact Assessment, as policy options for effective interventions in criminal justice are explored, has never been stronger.

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