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Limited prison service resources a challenge for health care

Preliminary results of health survey make for grim reading

The preliminary findings of a health survey focusing on criminal sanctions recipients indicate that prisoners are people with severe mental and physical health problems (Criminal Sanctions Agency communication 2008). This is not surprising. As far back as 2002, a working group investigating prisoner health care reported that ever more seriously ill patients who are extremely difficult to treat and who have both chronic mental illnesses and life-threateningly severe drug withdrawal symptoms appear to be populating prisons.

Prisoners are many times more likely to be ill than the rest of the population. The preliminary findings of a health survey conducted by the Criminal Sanctions Agency indicate that 90% of the study subjects were in need of some kind of medical treatment. 50% of them were, for example, infected with hepatitis C. The prevalence of mental health problems among the prison population had also increased further from an already elevated level. Depression and bipolar affective disorder were, according to the survey, 2–4 times more common among inmates than in the general population. On average, 70% of the study subjects had some kind of a personality disorder, in addition to which about half were alcoholics and two thirds had been diagnosed with some intoxicant abuse symptoms. Up to 90% of male inmates were addicted to some or other intoxicant.

Imprisonment is usually considered a negative time period that leads to the accrual of more problems for prisoners. On the other hand, it is also possible to halt cycles of addiction and to treat mental disturbances, which are common among prisoners, during a custodial sentence. An estimated 60,000 Finns have been to prison at one time or another, so what happens during prison sentences is not entirely inconsequential for national health (the physician-in-chief of the Prison Mental Hospital Hannu Lauerma pointed this out in an article pub-

lished in the journal Vankeinhoito 4/2008). Treating the illnesses of prisoners and intervening in their health-negative behaviour is, however, challenging because custodial sentences are primarily short: over 60% of the prisoners who were released in 2008 had served a sentence of six months or less (Criminal Sanction annual report 2008).

The Parliamentary Ombudsman – a guardian of many

The Parliamentary Ombudsman exercises supreme oversight of legality in matters that concern prisons, as the Chancellor of Justice has, under the Act on the Division of Responsibilities between the Chancellor of Justice and the Ombudsman, been relieved of the duty of exercising oversight with regard to prisons and thus also of monitoring the health care services provided in these facilities. As no special provisions have been drafted on this matter, the National Authority for Medicolegal Affairs (TEO), which was tasked with directing and monitoring national health care activities up to the end of 2008, likewise lacked the authority to steer and oversee prison health care services. The National Supervisory Authority for Welfare and Health (Valvira), an agency of the Ministry of Social Affairs and Health that was established on 1 January 2009 and inherited the responsibilities of TEO, has not been granted this authority, either. Nor are the State Provincial Offices authorised to direct or supervise prison health care. Only if the case involves the conduct of an individual health care professional working in a prison do these authorities have a statutory right to exercise oversight.

In a decision concerning patient safety at the Prison Hospital (1538/05), the Deputy-Ombudsman considered the then National Authority for Medicolegal Affairs TEO's lack of authority problematic. He considered it inappropriate that the directing and supervision done by TEO did not extend to some organisations that provide health care services. This position was brought to the attention of the Ministry of Social Affairs and Health, but oversight of health care at correctional facilities has not, for now, been included in the tasks of Valvira.

Prisoner health care is statutory

Prison health care must be arranged in a way that provides prisoners with an opportunity to promote their health, prevent illnesses and avail of adequate health care services on a basis of equality with the rest of the population. The prison pays all of the costs of prisoner health care. The new Imprisonment Act brought dental care to, more or less, the same level as other health care services – earlier, prisons only had to provide dental care if this was necessary to

treat an illness or prevent substantial harm. Thus, a prison's duty of care nowadays encompasses more than just treatment of acute conditions. If it is not possible to treat or examine prisoners properly at the prison, they must be taken, under appropriate supervision, temporarily outside the prison for treatment or tests. According to information provided by the health care unit of the Prison Service, the provision of health care services, dental care included, to prisoners has the aim of complying with the time limits determined in the Treatment Guarantee, even though the Imprisonment Act does not contain references to provisions dealing with this.

Prisoner's right to personal security obligates prison authorities

As far back as 2002, the above-mentioned Criminal Sanctions Agency working group on prisoner health care stated that prisoner health care was heading for a crisis. It was, among other things, difficult to hire prison doctors and jails were more and more frequently being forced to rely on supply doctors, who were expensive to engage and worked on a short-term basis. This situation has not changed.

During a 2008 inspection visit to Finland, the European Committee for the Prevention of Torture (CPT), which works to prevent inhuman or degrading treatment or punishment, also focused attention on the inadequate health care resources in some prisons. The Committee thought that physician resources – unlike nurse resources – were not at a satisfactory level at any of the institutions it inspected. It also recommended that a person with first aid skills be always present at these institutions – at night as well – and that preferably this employee should be a registered nurse. The Committee focused special attention on the fact that no nursing staff members were present at night at the 15-bed psychiatric ward of the Vantaa Prison, even though the type of patient assigned to this ward is in need of constant supervision by a psychiatric nurse.

These same issues have also been considered at the office of the Parliamentary Ombudsman.

Patient safety endangered by level of nursing staff

In the final analysis, resources issues such as the availability of sufficient doctors and other nursing staff at health care units are fundamentally questions that involve political decisions. The monitoring of such matters is not directly included in the Ombudsman's oversight tasks.

However, if lack of sufficient resources affects the legality of activities, it is the responsibility of the overseer to intervene.

The Deputy-Ombudsman has expressed an opinion on resourcing issues in a decision concerning the level of medical staff (1538/05). He took the view that the low number of medical personnel at the Prison Hospital endangered patient safety; this pertained especially to night shifts, where a single nurse could be responsible for the welfare of 50 patients. This was very worrying, as the case involved the right to life, a fundamental and human right protected under Section 7 of the Constitution. Ultimately, it is the responsibility of the authorities to actively ensure that conditions are safe. The decision also emphasised that the multiply challenged nature of the patients in the Prison Hospital should be taken into consideration when allocating staff resources. The number of nursing staff in the Prison Hospital was markedly lower than in, for example, a municipal health centre ward. Staff numbers in the Prison Hospital have since been increased to a degree that safeguards round-the-clock preparedness for emergency duty. Furthermore, the number of beds in the Prison Hospital was reduced to 36 as of the beginning of 2009, and this has brought its personnel strength and emergency duty preparedness to the level prevailing at other health care facilities.

Lack of emergency duty system weakens the personal security of prisoners

The inadequate resources in the Prison Service's health care unit were also revealed in a decision concerning the monitoring of prisoners who had been placed in supervised isolation (133/08). The prison nurse was informed about the transfer of a prisoner into supervised isolation only some 21 hours after the fact, which was clearly in violation of the Imprisonment Act's requirement to avoid undue delay. This delay could have been avoided if the prison had had an emergency duty system in place. However, such a system appears to be lacking in most prisons. The right of prisoners to personal safety in any event obligates the prison authorities to ensure that conditions in supervised isolation are safe, which is why health care personnel should be informed immediately when a prisoner is placed in isolation. The Deputy-Ombudsman's view was that the evaluation and safeguarding of the state of health of isolated prisoners as required under the law, outside office hours and on weekends as well, calls for the establishment of an organised emergency duty system and the allocation of additional resources for health care units.

The Criminal Sanctions Agency has reported that a comprehensive emergency duty system cannot be established in the health care unit of the Prison Service because this would require the Service to renegotiate employment contracts with its health care staff and to hire

additional staff. This has prompted the CSA to propose to the Ministry of Justice that the Imprisonment Act be amended to include an obligation to inform, without delay, a health care professional about the state of health of prisoners being placed under observation and supervised isolation; the prisoner's state of health should also be examined by a physician or other health care professional as soon as possible. In practice, the amendment would mean that a notification could also be made to a health care professional outside the Prison Service who would not have to have the official status of a public servant. A prisoner could likewise be examined by an external health care professional such as a supply doctor. At time of writing, the Deputy-Ombudsman had not yet expressed a view on the Criminal Sanctions Agency's report.

Prison Service report concerning physician resources

In 2008, the Office of the Parliamentary Ombudsman began to examine the physician resources of the Prison Service, with particular attention focusing on the amount of procured services needed to take care of prisoners. The report received indicates that it is difficult to find doctors to fill vacancies in prisoner health, particularly in northern Finland. The Prison Service has in fact had to rely quite heavily on the services of supply doctors to provide necessary health care services. It should be considered worrying that only 13 full-time appointed doctors were engaged in the treatment of prisoners at the time of examination; nine of these held office at a hospital. Otherwise, the physicians were either supply doctors or worked as fee-based prison doctors – this means that more that half of all prison doctors are not employed in this position full-time. This has inevitably led to a situation in which the day-to-day basic health care of prisoners is to a large degree the responsibility of nurses working in prison clinics. Although they are competent and committed to their work, they are not licensed physicians and they are not authorised to make decisions concerning the treatment of prisoners. In fact, they constantly have to rely on, for example, telephone consultations with a doctor to get a decision on a prisoner's treatment with regard to, inter alia, medication. This situation is not desirable from the point of view of the patient or from the perspective of health care professionals.

Using supply doctors to provide public health care services is not unproblematic either. A supply doctor is in a contractual employment relationship with a company that hires out health care staff. He or she is thus not in the official service or comparable employment of a public body in spite of being stationed at a public health care unit. Supply doctors cannot therefore be considered public servants and their possible responsibility for the legality of their actions cannot be based on the nature of their employment relationship; instead, it is whether or not they wield public authority in their position that determines if they are subject to the account-

ability for their actions that public servants bear. This leads to a situation where patients are placed in an unequal position depending on whether they are treated by an appointed doctor or a supply doctor because an appointed doctor is subject to official liability, which does not depend on the actual nature of the tasks being performed. The Ombudsman has found it unsatisfactory that, under current legislation, it is also not clear in which tasks a doctor working for public health care – such as a health centre physician or hospital consultant – wields public authority. The Ombudsman has asked the Ministry of Social Affairs and Health for a report on the matter; the deadline for this report had not yet expired at time of writing.

From the health care perspective, prisoners are patients who are entitled to patient rights

For employees of the Prison Service health care unit, prisoners are patients and health care regulations must be observed in their treatment. Members of the security staff of prisons are, on the other hand, subject to the provisions of the Imprisonment Act and must fulfil the obligations stipulated in them. It is not possible to avoid conflicts, and situations will inevitably arise where it is necessary to seek a balance between the different regulations in practice.

Authority of health care staff to utilise restraint measures differs from security staff

During its most recent inspection visit to Finland, the CPT focused attention on the psychiatric ward in Vantaa Prison, whose health care staff were responsible for the treatment of restless patients only to a very limited degree, as this responsibility had been placed on the security personnel of the prison. As an example, the report mentioned a patient in voluntary treatment whom staff had been unable to placate, after which this individual was treated as a prisoner who was refusing to obey an order and not as a patient in distress. The report took into consideration that, in this situation, only security staff were authorised to place the patient in an isolation room involuntarily. Nevertheless, the Committee recommended taking action to ensure that the treatment of restless patients remains the responsibility of the ward's health care staff. The prison's security staff should provide all possible assistance for the handling of such patients under the instruction and close scrutiny of health care professionals.

As is revealed by the foregoing, Finnish legislation provides health care staff with very limited authority to intervene in the violent behaviour of patients. The provisions of the Act on the Status and Rights of Patients (Patient Act) are applied to voluntary health care treatment and they were not drafted with consideration to the need for restraining measures. The provisions

of the Patient Act also apply to the voluntary treatment of prisoners. It is important to realise that health care personnel and prison security staff must observe different regulations, which contain different rights to use restraint measures. If these disparities are not taken into consideration in practice, it is possible to end up in a situation where one or the other is in breach of the law.

Such a situation has been the subject of a decision by the Ombudsman. A remand prisoner was taken in limb restraints by ambulance from a prison to a hospital for observation in order to examine whether there were grounds to place the prisoner in involuntary treatment (2259/06). Health care legislation does not authorise a health care professional – in this case, the ambulance attendants – to restrict a patient's autonomy in a situation where the patient has not yet been admitted to hospital for observation or involuntary treatment. Nor did the case involve a situation where the justifiable defence or emergency provisions of the Penal Code could be applied. The security measures employed during the ambulance transport of the prisoner therefore had to be considered with regard to prison service regulations. Even so, restraining the prisoner for the duration of transport was an exceptional measure that should be employed only when it is considered indispensable in a specific individual case. The clarifications received on the matter unavoidably lead to the conclusion that security personnel have harboured a false conception of the authority of ambulance attendants to interfere with the patient's right of self-determination, which is why a decision to restrain the prisoner for the duration of transport had not been made at the prison. The Deputy-Ombudsman considered it obvious that the grounds for restraining the prisoner during transport required under the Remand Imprisonment Act in force at the time were not met.

Even prisoner-patients have a right to privacy

Confidentiality is a key aspect of the treatment relationship in health care. Patients must be able to believe that treatment will be arranged in a manner that respects their privacy and right of self-determination. This is not self-evident with respect to prisoners and in practice it is possible that third parties, i.e. warders, are present at the reception. Complaints lodged with the Ombudsman indicate that sometimes the presence of a warder is based on the operating policy of the prison and not on a case-specific assessment. It is not recognised that the individual's prisoner status changes to that of a patient at the reception of a health care professional; the patient's rights then have to give way to security aspects, whereas it would be more appropriate to actually consider ways in which to minimise the invasion of privacy without endangering security.

Several of the Deputy-Ombudsman's decisions have contained an expression of opinion on the right to privacy of a prisoner-patient at the reception of both prison doctors and doctors who practice outside prison. In these stances, the Deputy-Ombudsman's point of departure has been that prisoners are entitled to receive treatment without the presence of third parties just like other patients. Warders must be considered third parties in a treatment situation in spite of the fact that they are bound by confidentiality. The presence of a warder during treatment can only be allowed in exceptional situations when it would not otherwise be possible to take care of the guarding duty appropriately. Such exceptional situations could involve cases where the doctor requests the presence of a warder or if the security of health care personnel is otherwise endangered. If there are reasonable grounds to suspect that the prisoner will attempt to escape, the presence of a warder can also be considered justified so long as the threat of escape cannot be nullified through any other means. This means that the need for a warder to be present must always be assessed on a case-by-case basis, as a policy of automatically having a warder present when treatment is being administered to a prisoner belonging to, for example, a specific group cannot be considered acceptable. If it is not possible to completely avoid an invasion of privacy, the treatment situation should be arranged in a manner that minimises the invasion.

The physician's view on the need for the presence of a warder during treatment should be heard. Prisons have sometimes justified the presence of a warder by stating that a doctor had not said that it would inconvenience the treatment situation. However, the issue at stake is the patient's right to privacy, and not the doctor's, which means that a doctor cannot give consent on behalf of a patient. The presence of a warder at the reception may have become the general rule observed if, for example, the doctor has not had the opportunity to review the prisoner-patient's file in order to clarify whether or not he or she should feel at risk. This kind of conduct is problematic especially when it is known that prisoner health care is often provided by supply doctors. The warder's role as a provider of information is emphasised in these kinds of situations. The Deputy-Ombudsman has pointed out the importance of providing health care professionals with the opportunity to gather sufficient information on a prisoner-patient in order to be able to form a reasoned decision on the need for a warder's presence (3842/07). According to information received from the Criminal Sanctions Agency, prison doctors and nurses are entitled to access prisoner information system entries regarding the danger level associated with individual prisoners. It is not known whether or not this opportunity is availed of or to what extent part-time and supply doctors are aware of it.

The opinion of the prisoner-patient should also be heard in situations where the presence of a warder is considered necessary. If a third party is present in the treatment situation, this and the grounds for the decision should be entered into the patient's medical records in an

appropriate manner, in addition to which the documents should also indicate whether the patient was heard with respect to this decision. It is important – from the point of view of the doctor's legal protection, too – to ascertain whether or not the patient consents to the doctor disclosing confidential information to a third party, i.e. the warder in this situation.

In its comments, the CPT has also noted that, in prison, situations may occur in which special security measures are necessary during medical examinations. The Committee has mentioned as an example situations where health care personnel feel that their safety is threatened. However, the Committee has pointed out that this does not mean that warders may always be present at the reception. In its recommendations, the Committee has required all medical examinations of prisoners to be arranged in a manner that keep warders out of earshot or – unless requested otherwise by a doctor or nurse in a specific individual case – out of the line of sight of the warders.

At times these settings can lead to a situation where the prisoner refuses to tell the doctor information related to his or her state of health if a warder is present. If the doctor considers it impossible to continue the reception without the presence of a warder – and as the doctor is not entitled to reveal matters concerning the prisoner's state of health in the presence of a warder without the consent of the prisoner – it is not possible to continue the reception, and the prisoner's reason for coming there will not be examined, at least not then. This outcome is disadvantageous from the point of view of the prisoner-patient because he or she has only limited opportunities for seeking treatment elsewhere. This can lead to a situation where the prisoner is forced to yield his or her right to privacy in order to receive appropriate treatment. According to a view expressed by the Deputy-Ombudsman, the development of prisoner health care should take into consideration the prisoners' right to privacy and how this could be promoted without endangering the safety of health care professionals (1302/05).

The right to privacy can also be endangered if it is the doctor's practice to keep the door open during reception. The Deputy-Ombudsman has considered such conduct questionable from the perspective of the patient's right to privacy and the confidentiality of the doctor-patient relationship, even if the discussions conducted at reception cannot be heard in the waiting room (1302/05). The treatment situation should be arranged in such a way that enables patients to trust that their confidential information will not be revealed to outsiders without their consent. They cannot be certain of this if the door to the reception is kept open, or at least the patient has reasonable grounds for suspicion in such cases.

Use of telephone consultations weaken the prisoner-patient's right to be heard

According to the Act on Health Care Professionals, a licensed physician must decide on the medical examination, diagnosis and associated treatment, medication included, of patients. The small number and often part-time status of prison doctors have led to a situation where nurses working in prison clinics have to consult with doctors over the telephone to receive treatment decisions. Prisoners feel that this infringes on their patient rights, as their medication can be altered without the doctor even meeting them.

With regard to this issue, the Deputy-Ombudsman has noted that changing a patient's medication at a nurse's reception on the basis of a telephone consultation with a doctor is not, as such, unlawful (e.g. case 1061/05). A procedure where the physician responsible for administering medication might not already be familiar with a patient and does not ascertain the need for medication through a personal examination can, however, be criticised from the point of view of the legal protection of both the patient and the health care professional. It is worrying that this kind of procedure appears to be more like the rule than the exception in prisoner health care. Many problems are associated with this, for example with regard to how the provisions of different laws are taken into consideration in the situation. The Patient Act requires patients to be given an opportunity to be heard in matters related to their medication and for medication decisions to be subject to mutual agreement with the patient. According to a decree issued on the dispensing of medication, the prescriber of the medicine must supply the patient with sufficient information on the purpose and administration of the medicine. The Patient Act also contains provisions on the duty to provide the patient with a report on his or her treatment.

The prescriber is responsible for ensuring that the patient's need for medication has been appropriately ascertained before making a decision to medicate him or her. The prescriber is also fundamentally responsible for ensuring that the patient is heard and provided with appropriate information about the drugs being prescribed. If the prescriber of the medication does not meet the patient, he or she must nevertheless ensure that the requirements stipulated in, for example, the Patient Act are fulfilled and that the treatment instructions issued by him or her regarding, among other things, medication are understood correctly and entered into the patient's documentation. It is often also the case that medication prescribed through such telephone consultations is not the same as the medication requested by the patient, which makes it understandable that patients feel that their right to be heard in matters related to their treatment has been infringed.

Confidentiality of patient information not always realised in prison

In the foregoing, I have examined the prisoner's right to privacy at a doctor's reception and noted that warders do not have a statutory right to gain knowledge of information related to the health care of prisoners. This has clearly been the intention of the legislator, as has been indicated by, for example, the Eduskunta's deliberations concerning the Government Bill proposing an Act on the Handling of Personal Information in the Execution of Punishments (HE 26/2001 vp). This document proposed that a doctor treating a prisoner or some other health care professional under this doctor's instructions could, after having consulted with the prisoner, inform the director of the correctional facility if the prisoner has been infected with HIV or hepatitis or some other contagious disease deemed a danger to public health under the Communicable Diseases Act without being prevented from doing so by confidentiality provisions if this is necessary from the point of view of safeguarding the health and safety of the prisoner or other people and if it is the doctor's medical opinion that there is a special danger of the disease spreading.

According to the Legal Affairs Committee (LaVM 3/2002 vp), the proposed legislation represented a departure from the general confidentiality provisions that apply in health care and specify in more detail the right to privacy which is protected under Section 10 of the Constitution. In the view of the Committee, a weakening of the confidentiality of the treatment relationship and the curtailing of the confidentiality requirement in the proposed way were not absolutely necessary because the goal of protecting public health was obtainable through other means as well. For this reason the Legal Affairs Committee did not think it necessary to deviate from the health care sector's general patient information confidentiality and disclosure principles and regulations in the provision of health care services to prisoners.

According to guidelines issued to Prison Service staff on measures to be taken during conflict situations, each prisoner should be regarded as a possible carrier of a contagious disease and staff should take care of their personal protection. As HIV and hepatitis infections are fairly common among prisoners and because it is not possible to be aware of all infections, the observance of such a guideline is the best way to avoid infection. The Committee felt that a regulation such as that proposed could foster a false sense of security and lead to a deterioration in the observance of appropriate operating practices.

A right for health care professionals to disclose health information without the patient's consent was therefore not enshrined in the Act. It was, however, enacted that it would be possible to disclose, without the written consent of the patient, to professional staff of the Prison Serv-

ice working in non-health-care duties only such information related to the state of health or treatment of the patient that does not reveal the nature of the illness or other details of the patient's state of health or treatment. A further qualification is that the responsible doctor must consider the disclosure of such information necessary for the medical treatment or handling of the patient or from the point of the patient's own safety or the health and safety of other prisoners and staff members. Application of this provision will probably be quite rare in practice.

The Deputy-Ombudsman has had to express an opinion on the confidentiality of the patient records of prisoners in a decision concerning the dispensation of medicine at a prison (3998/07). It was the prison's practice to have the prison clinic's nurses place the drugs meant for each prisoner-patient in a so-called pill dispenser box. The warders were then responsible for handing the medicine out of the box to the prisoners. The names of the pharmaceuticals prescribed to the prisoner-patients had been marked on the bottoms of the dispensers. Although this procedure had the intention of aiding the work of the health care professionals, it also endangered the confidentiality of patient information because the warders could find out what medication the prisoners were on when they were handing out the pills. The Deputy-Ombudsman considered this procedure unlawful and said that the safe practical organisation of medication would need to be ensured in some other manner. The health care unit of the Prison Service has reported that it has commenced the planning of measures to arrange the distribution of pharmaceuticals lawfully and in a way that does not endanger the safe implementation of medication.

This opinion of the Deputy-Ombudsman does not change the fact that, in practice, warders will be able to recognise different pharmaceuticals on the basis of their shape and colour, meaning that what is marked on the bottom of the pill dispenser box is not necessarily significant in any way. The low level of available health care resources causes the fact that warders, instead of health care staff, are responsible for handing out medication to prisoners. On the other hand, it can be asked whether warders should be aware of some factors related to the state of health of prisoners. As the handing out of medication is often the responsibility of warders, it could even be deemed necessary for them to know about the properties of these pharmaceuticals. In a situation where a prisoner experiences a bout of illness in his or her cell, it would surely be beneficial if the warders were aware of the prisoner's possible underlying illnesses such as diabetes or epilepsy. These situations can occur – and in fact often do occur – at a time when members of the prison's health care staff are not available to provide information concerning the afflicted prisoner. In such an event, the prisoner's right to privacy could turn against his or her own best interest.

Medication and changes made to it cause much discontent among prisoners

A large portion of the complaints made to the Ombudsman about prison health care deal with medication and often concern situations in which prisoners no longer receive the medication they desire and may have been on for several years prior to being sentenced to incarceration. These cases often involve pharmaceuticals that primarily affect the central nervous system (CNS drugs) such as benzodiazepines. In their complaints, the prisoners have said that the explanation they are given for this is that the pharmaceutical they desire is not included in the prison's basic range of drugs. However, the matter is not as straightforward as this because prison doctors may prescribe a drug that is not included in the prison's basic range if they consider it to be in the best interests of the patient.

According to the physician-in-chief of the Prison Mental Hospital Hannu Lauerma, benzodiazepines, which relieve anxiety and often cause dependence, are only used in prisons in rare and exceptional situations, and only for very short periods because addiction problems and illegal trade activities emerge very easily among the prison population. Other pharmaceuticals are used to substitute for these sedatives, which are referred to as "roofies" or "benzos" by the prisoners. Lauerma says that it is often not even justified to completely suppress anxiety, which is a basic mental feeling much like pain is a physical sensation, even though this is the wish of some prisoners. Anxiety can, just like pain, be an incapacitating dysfunction, but in some situations it is a necessary signal, prompting those who experience it to alter their behaviour or outlook. A capacity to feel and tolerate a certain amount of anxiety is a prerequisite for normal life. From this perspective, it is quite understandable that when, for example, prisoners begin to be weaned off medication at the start of their incarceration, they will feel like their state of health is deteriorating and that the new medication they may have been prescribed is ineffective.

The Deputy-Ombudsman has expressed an opinion on several complaints about the medication of prisoners in which the main issue has been the weaning of prisoners from benzodiazepines during their imprisonment. His view has been that the need for medication should always be assessed individually on the basis of what would be medically justified for each patient. The prison's basic range of drugs or a "treatment policy" that has been adopted by the prison may not determine what type of medication would be medically justified for the treatment of an individual patient. This is so in spite of the fact that the prison population includes people whose behaviour is intoxication-oriented and who attempt to secure pharmaceuticals for non-medical purposes. In some cases, the then National Authority for Medicolegal Affairs (TEO) was asked for a submission concerning the medical justification for wean-

ing a specific prisoner-patient off medication and whether the wearing was otherwise performed appropriately. TEO stated that benzodiazepines lent themselves especially well for abuse because of their pharmacological properties. This is why special care and caution must be observed when prescribing them. The prescriber is responsible for ensuring that this medication is medically justified and safe for the patient. In none of the cases brought before it for evaluation did TEO find that the prisoner-patient was suffering from a mental illness of disorder of a type, which would have made long-term benzodiazepine medication justified from the medical perspective.

This can be confusing, especially when the prisoner has been on CNS medication prescribed by a doctor outside the prison. Explanations received from prison doctors have, from time to time, expressed an opinion on this. On the basis of these opinions, it is possible to infer that doctors who practice outside of prison do not always follow a consistent policy in prescribing pharmaceuticals of this type. They are unable to consistently deny medically unjustified demands for CNS drugs that are clearly or presumably intended for abuse. The thankless task of weaning prisoners from medication is then left to the prison doctor, and this quite naturally erodes the prisoner's confidence in the prison's health care services. Prisoners often refer to the Patient Act, according to which patients must be treated consensually. The Patient Act's provision on this matter does not, however, mean that the prescriber of medication should consent to a treatment suggested by the patient in situations where doing so is not medically justified or if it is impossible to ensure the safety of such treatment.

The Prison Service's treatment guidelines can sometimes prevent prisoners from receiving the health care services they need

The preliminary findings of the health survey of criminal sanctions clients indicate that there are many prisoners with hepatitis C in the prisons of Finland. The policy of the Prison Service's health care unit is to not commence treatment of hepatitis C (interferon treatment) in prison and to instead have it implemented in the prisoner's own hospital district after he or she is released. This policy also applies to prisoners serving life sentences. The Deputy-Ombudsman requested the National Supervisory Authority for Welfare and Health to assess the appropriateness of this policy. According to the Authority's submission, treatment of hepatitis C has developed substantially in recent years and there has been a shift from just monitoring the illness to earlier active treatment even in milder cases. For this reason the Prison Service's policy can lead to an unreasonable delay in the treatment of this illness and possibly cause negative health effects, especially for prisoners serving long sentences. In the

view of the National Supervisory Authority for Welfare and Health, there was reason to adjust the Prison Service's policy so that the treatment plan for each prisoner who is infected with hepatitis C would be based on a treatment and monitoring plan and priority assessment performed by health care specialists.

The Deputy-Ombudsman's decision noted that the Prison Service's policy regarding the treatment of hepatitis C did not in all cases sufficiently safeguard the prisoner's right to receive health care services and medical treatment which are of a high standard and in accordance with his or her medical needs. In these situations the prisoner's constitutional right to receive adequate health care services is not realised. The health care unit of the Prison Service was requested to explain the measures it had undertaken with regard to its interferon treatment policy (1833/07). This report had not yet been furnished at time of writing.

Thoughts on the future – in what direction is prisoner health care being steered?

Among other things, the Finnish Government's response to the CPT report states that, with regard to the Committee's criticism of the Prison Service's health care staff resources: "The reorganisation of the criminal sanctions sector involves questions about whether the Prison Service's health care should be incorporated into society's general health care system." This option is not deliberated any further in the response, so it remains up to conjecture what it would amount to in practice. The Government Bill introducing an Act on the Criminal Sanctions Agency (HE 92/2009 vp) notes that the health care unit is a unit belonging to the organisation of the CRA. This Act is intended to enter into force on 1 January 2010. According to the Bill, the role of the health care unit and its relationship with other public health care is being examined as part of the Ministry of Justice's productivity programme. It is clear that the situation in prisoner health care is poor resource-wise and that current budgets do not always ensure that prisoners are provided with the treatments to which they are entitled. In other words, prisoner health care is in need of additional resources; this sits uneasily with the savings targets set for prisons in the Government's productivity programme. It remains to be seen whether or not these resources can be found in some other part of the budget.