Health care in police watch-houses: a challenge and an opportunity

Police watch-house detainees have complex health needs that involve multiple agencies and require coordinated, interagency solutions

Julia L Crilly[1,2]
Caitlin Brandenburg[2]
Stuart A Kinner[3,4]
Ed Heffernan[5]
Joshua Byrnes[2]
Cathy Lincoln[1]
Paul Gardiner[6]
Peter Davidson[7]
Annabel Somerville[8]
Daniel Wilson[9]
David Green[1]
Stuart Thomas[10]

1 Gold Coast Hospital and Health Service, Gold Coast, QLD.
2 Griffith University, Gold Coast, QLD.
3 Curtin University, Perth, WA.
4 University of Melbourne, Melbourne, VIC.
5 Queensland Health, Brisbane, QLD.
6 Queensland Police Service, Brisbane, QLD.
7 University of California San Diego, San Diego, CA, USA.
8 Cairns Hospital and Health Service, Cairns, QLD.
9 Queensland Ambulance Service, Brisbane, QLD.
10 RMIT University, Melbourne, VIC.

julia.crilly@health.qld.gov.au

doi: 10.5694/mja2.51688

Police watch-houses (Queensland term) are buildings designed "for the temporary holding of prisoners before prisoners are released or transferred to a corrective services facility or detention centre".[1] They may also be used to hold people who are intoxicated, appear mentally ill, or are awaiting trial.[2] Watch-houses are also referred to as police cells, station cells, lock-ups, holding cells, jails, and custody suites in other Australian jurisdictions and countries. "Temporary" means "overnight or for 24 hours or longer",[1] and can be as long as 4 weeks.[2,3] In Queensland, watch-houses are staffed primarily by police officers, in some cases assisted by civilian watch-house officers.

Common problems faced in prison health care include vulnerability, physical and mental stress, and associated social determinants of poor health.[4] These are reflected among watch-house detainees.[5,6] A review of 505 coroners' reports pertaining to deaths in police custody in Australia between 1991 and 2016 revealed that 43 (9%) occurred in a police station, police vehicle, police cell, or watch-house;[7] of these, 15 occurred in Queensland, and 17 were Aboriginal or Torres Strait Islander people. The primary cause of those 43 deaths was medical (49%), followed by suicide (33%), accident (2%), intentionally killed (2%), and other (14%).[7] As a group, detainees are largely disconnected from health services, so beyond their immediate, untreated health problems, comparatively little is known about underlying and unaddressed social determinants (eg, homelessness, unemployment, poor education, low incomes).

United Nations Mandela Rule 24.1 stipulates that prisoners are entitled to medical care that is equivalent to that which they could access in the community.[8] While complying with the Mandela Rule has challenged Australian prisons,[9] the extent to which this includes the watch-house setting is unclear. A study of detainee experiences in Victoria indicates significant challenges, with reports of deprivation of material comfort, dignity and respect, and exposure to harsh, hostile, overcrowded and degrading environments.[2]

Access to health care in short term custody settings can be hampered by a range of underlying contexts, structures and processes of health care delivery.[10] Evidence predominates from the United States and United Kingdom.[10] To further advance reform in this neglected area, our group has been investigating strategies used at several geographically diverse police watch-houses across Queensland. This follows on from single-site research reporting that situating an emergency trained nurse within a watch-house yielded multiple positive impacts,[11] including reducing unnecessary detainee transfers to the emergency department (ED) and associated costs. This article highlights key challenges for the people and systems responsible for the health and safety of detainees in Queensland, and identifies potential opportunities to reduce the burden on these systems and improve access to appropriate health care.

Challenges

Overseas, the health needs of detainees in police custody represent challenges at individual, system, and inter-agency levels.[12] It is important to understand these challenges in the Queensland context to inform opportunities to drive equitable, cost-effective strategies for this population.

Challenges relating to individuals

- Detainees have significant health complexities with higher rates of mental illness, substance dependence and communicable diseases[11] than the broader community.[13] In addition, they commonly present with acute exacerbations of chronic conditions such as diabetes mellitus, hypertension, asthma, substance dependence, and mental illness.[12-14] They may also be acutely injured, intoxicated and/or distressed owing to the circumstances surrounding their detention, which may mask symptoms or hinder timely health assessment.
- Detainees commonly have complex social needs. They often belong to multiple categories of vulnerable populations.[15] This is especially evident

for Aboriginal and Torres Strait Islander people, who represent 30% of the custodial population[16] despite comprising only 3.3% of the Australian population.[17] The prevalence of mental disorder among Indigenous adults in Queensland custody is very high (males, 73%; females, 86%) compared with community estimates,[18] highlighting both layered vulnerability and the need for culturally appropriate responses.

- Autonomous decision making is limited for detainees. Detainees have little autonomy in decisions about their own health care and rely on police assistance to access services. Some may be motivated to under-report or over-report health issues, either because they are mistrustful of those responsible for their health care access (eg, the police), or in an effort to leave the watch-house environment to receive care.[19] This has led to recommendations for alternative approaches enabling medically trained staff to be on-site to assess, monitor and reassess detainees.[20]

Challenges relating to systems

- Watch-houses are not health care settings and are not necessarily well equipped to manage health care delivery. Similarly, health care settings such as EDs are not custodial settings. Hence there are inherent risks when transferring detainees out of a secure setting and into a health care setting, including the risk of absconding, risks to staff safety, and risks to the health of the detainee while in transit. The remoteness of some watch-houses and police cells, especially in Queensland, can mean slower coordination with health services, placing more burden on watch-house staff to correctly identify and respond to acute medical needs.
- Watch-houses are not prisons. Unlike prisons and youth detention facilities, watch-houses may have both children and adults of different genders, all requiring segregation. Managing such segregation during a pandemic, and where detainees may be a particular risk to themselves or others, can add extra complexities to an often already crowded and challenging environment.
- Police staff are not health care professionals but are expected to have a role in health screening of detainees[10,19] and delivering some minor care (eg, medication administration).[19] Many watch-house detainees have health problems which necessitate a rapid and effective response that may include forensic medical officer, general practitioner, government medical officer or nurse consultation (via phone or in person), ambulance service call-out, and ED transfer. Common reasons requiring an ED transfer pertain to trauma and toxicology related problems.[11] Given the duty of care owed to detainees by police, a risk mitigation approach often guides decision making for transportation. Although evidence-based guidelines exist to inform health care delivery in prison settings,[21,22] there is limited evidence to guide health care management for detainees in police watch-houses.[10]

Challenges relating to connections between agencies

- United Nations Mandela Rule 24.2 requires continuity of care between custodial and community health care services.[8] This is complicated by the wide range of providers involved in the health care of detainees. These agencies may have different communication preferences, organisational cultures, professional terminology, procedures, and sometimes different objectives. Adding to this, privacy issues surrounding sharing of health information are complex, and health care providers in watch-house settings may have difficulty accessing necessary health information in a timely fashion.
- Understanding of contextual capabilities between agencies is required. Re-engaging detainees who were previously disengaged from health services before watch-house entry[13] may be hampered by uncertainty regarding their discharge destination. Furthermore, processes in one system can affect another. Health care services therefore need to plan care around criminal justice processes and outcomes that may not yet be determined (eg, bail, release, imprisonment), leading to uncertainty regarding provision of ongoing or follow-up care.
- There are considerable costs of health care for watch-house detainees. Such costs relate to in-watch-house health care covering health care personnel (with varying models noted in the literature),[10] medications, and general medical supplies; and police escort and guard costs for transfer to and treatment in external health care settings.

Opportunities and a way forward

Despite the myriad challenges, watch-house detention provides a unique opportunity to intercept a vulnerable, complex and otherwise hard-to-reach population, and identify unmet health needs.[23] As has been suggested for prisons, health training for all staff working in watch-houses should include social determinants of health.[4] Given the high rates of Indigenous Australians in custody,[16] further investment in resourcing for culturally capable care, especially mental health services, is also needed.[18]

The short term nature of watch-house detention limits the potential to achieve sustained health improvements for detainees, although brief interventions for some health needs[24] (eg, substance use, sexual health screening, vaccination) may be effective. Increased access to health care providers in watch-houses would improve assessment, triage and management of some health problems. This could help minimise adverse outcomes, and potentially reduce unnecessary and resource-intensive transfers to EDs. Consistent with World Health Organization recommendations for prisons,[21] models of health care in watch-houses should be closely linked with public health services and, ideally, administered by a health care agency rather than the police service. Consistent with this, understanding the expected roles of the health

team and those of the police watch-house would be imperative.

Further investment in interagency strategies is needed to reduce the burden on police and EDs, and ensure appropriate care for detainees. Potential strategies should balance the risk of unnecessary transport to hospital with the imperative to address the entrenched social, security and health challenges[25] at play in this especially vulnerable population. Continuity of care should be a key consideration in this context,[9] capitalising on the opportunity to link this population to ongoing services to support sustained improvements in health. A shared electronic medical record would be optimal; however, a broader governance framework that promotes integration between watch-house and community health care providers is needed to facilitate effective information sharing and continuity of care. These goals will require a sustained, coordinated investment in intersectoral collaboration. The overlap of health and law enforcement offers important opportunities to support health care delivery to detainees. It is time to capitalise on these opportunities.

Acknowledgements: This work was supported by funding from the Emergency Medicine Foundation.

Competing interests: No relevant disclosures.

Provenance: Not commissioned; externally peer reviewed. ■

1 Queensland Police Service. Operating Procedure Manual. Chapter 16 – Custody. https://www.police.qld.gov.au/sites/default/files/2022-01/OPM%20-%20Chapter%2016%20-%20Custody.pdf (viewed June 2022).

2 Walker S, Higgs P, Stoové M, Wilson M. "That's the lowest place on earth!" Experiences of the carceral spaces of Australian police custody for marginalized young men. *Qual Health Res* 2020; 30: 880-893.

3 Zeng Z. Jail inmates in 2017. US Department of Justice Bureau of Justice Statistics (NCJ 251774). April 2019. https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6547 (viewed May 2022).

4 World Health Organization. Prisons and health. https://www.who.int/europe/health-topics/prisons-and-health (viewed June 2022).

5 Ogloff J, Warren L, Tye C, Blaher F, Thomas S. Psychiatric symptoms and histories among people detained in police cells. *Soc Psychiatry Psychiatr Epidemiol* 2011; 46: 871-880.

6 Walker S, Higgs, P, Stoove M, Wilson M. "They just don't care about us!": Police custody experiences for young men with histories of injecting drug use. *Aust NZ J Criminol* 2020; 53: 102-120.

7 Walsh T, Counter A. Deaths in custody in Australia: a quantitative analysis of coroners' reports. *Curr Issues Crim Justice* 2019, 31: 143-163.

8 United Nations Office on Drugs and Crime. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf (viewed June 2022).

9 Mackay A. The relevance of the United Nations Mandela rules for Australian prisons. *Altern Law J* 2017; 42: 279-285.

10 Wardrop R, Ranse J, Chaboyer W, Crilly J. Structures, processes and outcomes of health care for people detained in short-term police custody settings: a scoping review. *J Forensic Leg Med* 2021; 81: 102198.

11 Crilly J, Lincoln C, Scuffham P, et al. Effect of a 24/7 nursing presence in a police watch house on police presentations to the emergency department. *Aust Health Rev* 2020; 44: 924-930.

12 Rekrut-Lapa T, Lapa A. Health needs of detainees in police custody in England and Wales. Literature review. *J Forensic Leg Med* 2014; 27: 69-75.

13 Ceelen M, Dorn T, Buster M, et al. Health-care issues and health-care use among detainees in police custody. *J Forensic Leg Med* 2012; 19: 324-331.

14 Ogloff JR., Thomas SD, Luebbers S, et al. Policing services with mentally ill people: developing greater understanding and best practice. *Aust Psychol* 2012; 48: 57-68.

15 McKinnon I, Grubin D. Health screening in police custody. *J Forensic Leg Med* 2010; 17: 209-212.

16 Australian Bureau of Statistics. Prisoners in Australia. 9 Dec 2021. https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release#:~:text=From%2030%20June%202020%20to,prisoners%20per%20100%2C000%20adult%20population (viewed June 2022).

17 Australian Institute of Health and Welfare. Profile of Indigenous Australians. 7 July 2022. https://www.aihw.gov.au/reports/australias-health/profile-of-indigenous-australians (viewed July 2022).

18 Heffernan EB, Andersen KC, Dev A, Kinner S. Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons. *Med J Australas* 2012, 197: 37-41.

19 McKinnon I, Finch TL. Contextualising health screening risk assessments in police custody suites – qualitative evaluation from the HELP-PC study in London, *UK. BMC Public Health* 2018; 18: 393.

20 Office of the State Coroner, Queensland Courts. Findings of Inquest: Inquest into the death of Herbert John Mitchell. 14 Dec 2012. https://www.courts.qld.gov.au/__data/assets/pdf_file/0008/170774/cif-mitchell-hj-20121214.pdf (viewed June 2022).

21 Møller L, Stöver H, Jürgens R, et al, editors. Health in prisons: a WHO guide to the essentials in prison health. Copenhagen: WHO Regional Office for Europe, 2007. https://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf (viewed June 2022).

22 Royal Australian College of General Practitioners (RACGP). Standard for health services in Australian Prisons (1st edition). Victoria, Australia: RACGP. 2011. https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20standards/Health-services-in-Australian-prisons.pdf (viewed June 2022).

23 Lord Bradley. The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London: Department of Health, 2009. https://webarchive.nationalarchives.gov.uk/ukgwa/20130123195930/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694 (viewed June 2022).

24 Addison M, Mcgovern R, Angus C, et al. Alcohol screening and brief intervention in police custody suites: pilot cluster randomised controlled trial (AcCePT). *Alcohol Alcohol* 2018; 53: 548-559.

25 van Dijk AJ, Herrington V, Crofts N, et al. Law enforcement and public health: recognition and enhancement of joined-up solutions. *Lancet* 2019; 393: 287-294. ■