REPORT OF
THE NSW PRISON MEDICAL SERVICE
REVIEW COMMITTEE

to the

Hon. John Hannaford, M.L.C.,
Minister for Health and Community Services

August 1991
The Hon. John Hannaford, M.L.C.,
Minister for Health and Community Services,
NSW Department of Health,
73 Miller Street,
NORTH SYDNEY NSW 2060

Dear Minister,

I am pleased to submit the Report of the Prison Medical Service Review Committee.

The task of the Department of Health in providing health care to prisoners in NSW is undoubtedly a difficult one. Many prisoners enter the prison system with pre-existing health problems, as a result of years of neglect and an inability or unwillingness to access health services. There is a high incidence of psychiatric disturbance and many prisoners have histories of substance abuse. The prison environment contributes to boredom, frustration and powerlessness, and leads to a high demand for health services.

Although some gaols and facilities are modern and purpose built, many were not built with health care in mind and are plainly inadequate. Security considerations and logistical problems govern all operations. Health care staff work in locations run by people with a custodial rather than a health orientation. In addition, the prison population is expanding at a rapid rate and the Prison Medical Service is required to meet the corresponding health demands as well as to provide additional services, such as methadone and compulsory HIV testing.

Despite these difficulties, standards of health care are considerably higher than even a few years ago. There are many dedicated individuals in the Prison Medical Service who provide the highest standard of health care to prisoners and who are committed to providing the same standard of care as that received by members of the general community.

However, the Committee has identified some serious problems with the Prison Medical Service which require urgent attention. They include the quality and quantity of psychiatric and dental services, HIV/AIDS and Methadone counselling, and health screening of prisoners on reception. In particular, major problems became evident in the structure, management and budgeting of the Prison Medical Service.

The Committee has made a number of recommendations which should go a long way towards redressing these and other problems. A key recommendation of the report is the establishment of a Prison Medical Service Management Board. The Committee believes that such a Board can be established at little additional cost and will lead to increased efficiency and accountability of the Prison Medical Service.
The principle of equality of services is of fundamental importance to the operation of the Prison Medical Service. The report strongly endorses this principle, and it forms the foundation of the Committee's review. The Committee believes that unless there are compelling reasons to the contrary, the PMS should operate in the same manner as other agencies providing health care.

The Committee is indebted to all those who contributed to the report - nurses, doctors, psychologists, Superintendents, prison officers, administrators in the Department of Health and the Department of Corrective Services, and prisoners. It is particularly grateful to Kerrie Auton and Mary Harb of the Mental Health Branch of the Department of Health, who spent many hours typing the report.

The Committee looks forward to action on its recommendations.

Yours faithfully,

Noel M. Wilton,
Convener
MEMBERS OF PRISON MEDICAL SERVICE REVIEW COMMITTEE

Members of the Prison Medical Service Review Committee were:


- Mr Alan Davis, B.A. (Econ.), M.Sci Soc.

The Project Officer for the Review was Ms Alexis Hailstones, B.Juris, LLB.
(ii)

TERMS OF REFERENCE

1. To examine, report and make recommendations to the Minister for Health on the standards of care provided by the Prison Medical Service to persons detained in Department of Corrective Services institutions and Department of Family and Community Services juvenile justice institutions in New South Wales, having particular regard to:

(i) The organisation and administration of the Prison Medical Service.
(ii) The availability and adequacy of medical services.
(iii) The availability and adequacy of psychiatric services.
(iv) The availability and adequacy of other treatment programmes.
(v) Clinical issues arising in the delivery of services as in (ii), (iii), (iv), for example records, medication.
(vi) The provision of appropriate health services to specific groups including women, juveniles, Aboriginal Australians and drug users in custody.
(vii) The relationship of the Department of Health with the Department of Corrective Services in the provision of health services to prisons.
(viii) The relationship of the Department of Health with the Department of Family and Community Services in the provision of health services to juvenile justice institutions.
(ix) The relationship of the Department of Health to other agencies in the provision of services by the Prison Medical Service.

2. The Committee has powers to co-opt additional members.
CORRIGENDUM

REPORT OF THE N.S.W. PRISON MEDICAL SERVICE REVIEW COMMITTEE

Page 35  4th line: Under the Prison's Act, and an authorised ....

Page 65  Last paragraph, 2nd line: 0.68%

Page 76  16.4, 2nd paragraph, 2nd line: .... responsibility. Both are "authorised prescribers" for ....

Page 89  18.6, 2nd paragraph, 2nd line: 0.68%

Page 100  20.5, last line, 0.68%

DATE DUE

26.2.1996
5 SEP 1996
03 DEC 1996
15/9/97
# LIST OF ABBREVIATIONS USED

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACON</td>
<td>AIDS Council of NSW</td>
</tr>
<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
</tr>
<tr>
<td>DOCS</td>
<td>Department of Corrective Services</td>
</tr>
<tr>
<td>DODO</td>
<td>Directorate of the Drug Offensive</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>FACS</td>
<td>(Department of) Family and Community Services</td>
</tr>
<tr>
<td>NCADA</td>
<td>National Campaign Against Drug Abuse</td>
</tr>
<tr>
<td>NUM</td>
<td>Nursing Unit Manager</td>
</tr>
<tr>
<td>PDC</td>
<td>Periodic Detention Centre</td>
</tr>
<tr>
<td>PMS</td>
<td>Prison Medical Service</td>
</tr>
<tr>
<td>VMO</td>
<td>Visiting Medical Officer</td>
</tr>
</tbody>
</table>
PART ONE - THE CARE PROVIDED BY THE PRISON MEDICAL SERVICE TO PERSONS DETAINED IN DEPARTMENT OF CORRECTIVE SERVICES INSTITUTIONS

PART TWO - THE CARE PROVIDED BY THE PRISON MEDICAL SERVICE TO PERSONS DETAINED IN JUVENILE JUSTICE INSTITUTIONS
PART ONE
THE CARE PROVIDED BY THE
PRISON MEDICAL SERVICE
TO PEOPLE DETAINED IN
DEPARTMENT OF CORRECTIVE SERVICES INSTITUTIONS
SUMMARY

PART ONE - THE CARE PROVIDED BY THE PRISON MEDICAL SERVICE TO PERSONS DETAINED IN DEPARTMENT OF CORRECTIVE SERVICES INSTITUTIONS

The Committee to review the Prison Medical Service was established by the Minister for Health in 1990. Prior to the current review, other reports had touched on aspects of the Service. The Nagle Commission in 1975 and the Royal Commission Into Aboriginal Deaths in Custody in 1991 made a number of recommendations. This report is the first thorough and comprehensive review of the Prison Medical Service alone. A large number of recommendations are made as a result of comprehensive consultation by the Committee and following discussion with interested and affected people.

The Prison Medical Service provides health care to more than 6,000 adult prisoners in over 30 institutions in NSW. Most prisoners are located in the metropolitan area, but others are in gaols dispersed across NSW. The Service provides primary care, specialist and dental services through a combination of employed and sessional health care staff. The gaol population has a high morbidity rate, and there are a number of groups in prison with additional health needs. Aboriginal prisoners, prisoners with psychiatric problems and prisoners with intellectual disabilities are disproportionately represented in the prison population.

The Department of Corrective Services has a statutory responsibility to provide medical attendance, treatment and medicine to adult prisoners. This is provided by the Prison Medical Service, which is established under the Public Hospitals Act and is responsible to the Department of Health. The Committee believes that responsibility for the Prison Medical Service should remain with the Department of Health, and that a Management Board for the PMS should be established by the Minister.

The Committee has identified a number of organisational and management problems in the Service. To assist in overcoming these, a number of recommendations have been made, relating to:

- the establishment of a Management Board for the PMS
- the establishment of the position of a Chief Executive Officer
- a clear separation of management and clinical functions within the PMS

These arrangements are consistent with developments in health care services and should lead to increased efficiency and accountability for the PMS.

The current budget for the PMS is around $10.7 million. In budget adjustments over the years, no allowance has been made for the significant expansion of the prison population, and increased demands on PMS services. As a result, the current budget for the PMS is low by
comparison with other relevant indicators. The Committee believes that a population-based formula should be adopted as the basis for recurrent funding for the PMS, and that its current budget needs to be increased.

The Committee has identified problems in the level and extent of some services provided by the PMS. The principle of equality of care between prisoners and the general community is not being met, particularly in relation to psychiatric and dental services. The Committee believes that the adequacy of these services should be urgently reviewed.

Continuing education and training for all PMS staff is essential for efficient and effective services, and is of benefit to individuals and the organisation. Some deficiencies in these areas have been identified which the Committee believes should be remedied.

The overall health status of Aboriginal prisoners is generally lower than that of the general community. The Committee has addressed some of the problems of this group and recommends that services to Aboriginal prisoners be reviewed by the proposed Board.

Over 500 inmates are currently on the Prison Methadone Program. The Committee is aware of a number of problems relating to entry to the program, lack of compliance with guidelines, and security issues. It believes however that the program should continue, subject to a favourable evaluation, and subject to compliance with national guidelines.

Reception, assessment and health screening of prisoners is most important. In this respect the PMS can play a vital role in identifying prisoners facing risks of illness, disease and self-injury. The current reception and screening program is very limited. The Committee believes that a comprehensive multi-disciplinary health screening process should be urgently established for all prisoners received into custody.

The Committee’s report is divided into two parts. The first discusses the role of the Prison Medical Service in providing services to adult gaols. The second discusses its role in relation to juvenile justice institutions, more commonly called Detention Centres.

The Committee believes that implementation of the recommendations made will improve the productivity of the Prison Medical Service and enhance the health care provided to prisoners in New South Wales.
RECOMMENDATIONS - PART ONE

1. That the principle of equality of service with that of the general community be reaffirmed as the guiding principle for health care in prisons.

2. That a survey of the health status of inmates of NSW custodial institutions be commissioned by the Minister.

3. That occupational health and safety strategies consistent with the constraints of security requirements be developed in NSW gaols.

4. That administrative responsibility for the Prison Medical Service remain with the Department of Health.

5. That as a matter of priority a Board of Management for the Prison Medical Service be appointed by the Minister.

6. That membership of the Board be as follows:-
   - Chairperson
   - Department of Corrective Services nominee (1)
   - Department of Health nominee (1)
   - Community nominee (2)
   - Representative of Prison Medical Service Staff (1) (elected position)
   - Chief Executive Officer of the Prison Medical Service

7. That consideration be given to drawing community representatives from groups such as:-
   - Community Health Centres
   - Groups providing health services to specific groups e.g. Drug and Alcohol, AIDS Services
   - Universities
   - Aboriginal organisations
   - Women’s groups
   - Legal services
   - Prisoners’ organisations

Selection of the Board should ensure that there is management expertise available in its membership.

8. That the Board have policy, planning and operational functions including:-
   - determining objectives and priorities for the PMS
   - establishing policies to obtain those objectives
   - monitoring the achievement of those objectives
- assessing the appropriateness of proposals for change in the light of determined objectives
- managing services within the budget
- assessing the resource implications of proposals for change

9. That the Board report annually to the Minister.

10. That the Board develop:

(i) a strategic plan for the PMS, with a statement of aims and objectives which are consistent with UN standards and principles, and local health care initiatives; and
(ii) a formal policy outlining the principles of devolution of authority and responsibility within the organisation.

11. That the Board consider mechanisms for establishing formal and informal links with tertiary institutions and other medical and health-related agencies and personnel, such as community health centres and local general practitioners.

12. That the position of Chief Executive Officer of the PMS be established. This officer need not be a medical practitioner, but should have demonstrated administrative experience and management expertise.

Responsibilities of the Chief Executive Officer should include:
- implementation of Board policy
- administration of the PMS
- liaison with and provision of reports to the Board.

13. That in the organisational structure, appropriately qualified experts are identified to have the authority and responsibility for specific services including primary care, nursing, psychiatric and dental services.

14. That as far as possible, responsibility and authority for the administration of services be devolved to local unit level, with regional support provided to local managers.

15. That the budget allocation be adjusted annually to take into account any increase in the prison population.

16. That for the 1991-92 financial year, based on a notional allocation per prisoner of $2,400, the funding for the PMS be enhanced to a total of $14,097,000.

17. That the notional per-capita allocation be annually adjusted for inflation in line with Departmental practice.
18. That, as a matter of urgency, the Department of Health arrange for a financial audit of the Prison Medical Service, and ensure that appropriate monitoring and reporting systems are in place.

19. That the Board review the adequacy of GP and Specialist Services to inmates.

20. That the Board seek the co-operation of DOCS to review procedures for referral of inmates to GP and Specialist Clinics with a view to ensuring that delay for such services is kept to an absolute minimum.

21. That the Rose Scott Unit at Mulawa be closed immediately.

22. That facilities at Long Bay Prison Hospital again be made available to women prisoners.

23. That all gaols develop safe facilities for the observation of acutely disturbed prisoners which meet criteria determined by the Board and DOCS.

24. That appropriately trained health care staff be in attendance at all times when acutely disturbed or suicidal prisoners are identified.

25. That the Board urgently review the number of hours of psychiatrists’ time available to inmates.

26. That the NSW Institute of Psychiatry or a similar body be approached to develop psychiatric training courses for correctional health nurses.

27. That provision of therapeutic services to prisoners be a priority for PMS staff, taking precedence over other services such as preparation of court reports.

28. That except in relation to positions providing external security, the withdrawal of custodial staff from the psychiatric wards at Long Bay Hospital be negotiated between DOCS and the PMS, subject to adequate staffing and funding and following consultation with staff.

29. That the Board determine the optimum arrangements for the provision of medical services to women prisoners.

30. That the Prison Medical Service ensure that counselling is available to all inmates tested for HIV/AIDS, especially for those inmates who are HIV positive.

31. That the Department of Health policy aimed at preventing the spread of HIV/AIDS in prisons be implemented.

32. That the Board ensure that confidentiality in relation to HIV/AIDS is adhered to, in accordance with the policy of DOCS.
33. That a survey of the dental health status of inmates of NSW custodial institutions be commissioned by the Minister.

34. That the Board ensure that dental services provided within NSW gaols are of a level and standard similar to that available to the general community.

35. That links be developed between the Faculty of Dentistry of Sydney University and the Prison Dental Service.

36. That the Board review the availability of training for all PMS staff and develop a plan for continuing staff education.

37. That PMS nurses be encouraged to attend the Correctional Health Nursing Course.

38. That an orientation program be developed which will ensure that all staff are adequately familiarised with custodial and health issues relevant to providing health services in gaols.

39. That nursing staff receive appropriate training in psychiatric assessment and management.

40. That training be conducted to ensure that health care staff are familiarised with health needs of Aboriginal prisoners and other prisoners with specific health needs.

41. That annual updates be provided for nursing staff on emergency procedures, including cardio-pulmonary resuscitation.

42. That staff receive relevant management training prior to devolution of responsibility to local areas.

43. That the Board review the availability of trained interpreters to facilitate the provision of appropriate health care services to prisoners of non English-speaking background who require them.

44. That continuing education for staff in the PMS encompass training in working in multicultural environments.

45. That Aboriginal medical services be approached to provide sessional medical services to Aboriginal prisoners on a contractual basis.

46. That the Board as a matter of priority review the provision of health services to Aboriginal prisoners.
47. That the Prison Medical Service investigate ways to facilitate the recruitment of Aboriginal staff to the service.

48. That the Prison Methadone Program continue, subject to a favourable evaluation by DOCS and DODO.

49. That national guidelines relating to the administration of the Prison Methadone Program be strictly adhered to. Assessment, monitoring and dispensing procedures should be in accordance with strict medical practice.

50. That the paper prepared for the Committee by DODO be widely distributed to relevant people in DOCS, PMS and other agencies.

51. That a Prison Methadone Program Management Committee be established, consisting of representatives of the Prison Medical Service, DOCS, the Methadone Sub-Committee and DODO.

52. That a comprehensive multi-disciplinary health screening process be instituted for all prisoners received into custody.

53. That protocols be established for the transfer between police, DOCS and the PMS of information about the physical or mental condition of prisoners which may create or increase the risk of death or injury while in custody.

54. That safeguards be established to protect the privacy and confidentiality of health-related information about prisoners to the extent that is compatible with adequate care.

55. That relevant government organisations (DOCS, PMS, and the Department of Education) and community groups (e.g. the NSW Council on Intellectual Disability and the Australian Society for the Study of Intellectual Disability) work to develop appropriate screening indicators for intellectual disability.

56. That an adequate data base be established containing information about the health status of prisoners and the utilisation of health services.

57. That the Board review the data collection and records system for the PMS with a view to devising a functionally efficient system adapted to both planning and clinical needs.

58. That the computerisation of medical records in the PMS be further developed, having regard to privacy safeguards.

59. That the Privacy Committee be consulted where appropriate in relation to the record and information system of the PMS.
60. That where the Department of Health has an existing preventive care policy, this should be implemented as far as possible in the gaol system.

61. That quality assurance be applied to all services, including management services, provided by the PMS.

62. That the statement of duties for those clinically responsible in the new structure include the development of Quality Assurance strategies for the Prison Medical Service.

63. That staff be fully involved in the gradual introduction of quality assurance as standard organisational practice.

64. That steps be taken to investigate appropriate outcome criteria for health care services delivered in custodial settings.

65. That, in negotiations with the Commonwealth, the Minister consider the issue of the availability of Medicare benefits to prisoners on remand and prisoners subject to Periodic Detention.

66. That prisoners be formally advised on reception to gaol of their right to make complaints about the Prison Medical Service, and given information about the Complaints Unit and other avenues of complaint.

67. That information about complaints procedures be in a form appropriate for people of low literacy skills, and people whose first language is not English.
RECOMMENDATIONS - PART TWO

1. That the Minister for Health Services Management recommend to the Minister for Justice that health services for young offenders be provided by the Royal Alexandra Hospital for Children.

2. That negotiations be commenced immediately to achieve this objective.

3. That a Standing Committee be established to oversee the delivery of health care to young people in juvenile justice institutions.

4. That membership of the standing Committee be a representative of the Department of Health, a representative of DOCS, representative of the Attorney-General's Department, a representative of the Royal Alexandra Hospital for Children, and an independent community representative.

5. That the Standing Committee ensure that relevant recommendations made in the report to the Director-General of FACS be implemented and that appropriate standards be adhered to.
## CONTENTS

**PART ONE - THE CARE PROVIDED BY THE PRISON MEDICAL SERVICE TO PERSONS DETAINED IN DEPARTMENT OF CORRECTIVE SERVICES INSTITUTIONS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>INTRODUCTION</td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>The Need for a Review of the Prison Medical Service</td>
<td>2</td>
</tr>
<tr>
<td>1.2</td>
<td>Methodology for the Review</td>
<td>2</td>
</tr>
<tr>
<td>1.3</td>
<td>Role of the Prison Medical Service</td>
<td>3</td>
</tr>
<tr>
<td>1.4</td>
<td>History of the PMS</td>
<td>4</td>
</tr>
<tr>
<td>1.5</td>
<td>International Standards - Medical Care in Custodial Institutions</td>
<td>5</td>
</tr>
<tr>
<td>1.6</td>
<td>Statutory Background</td>
<td>5</td>
</tr>
<tr>
<td>1.7</td>
<td>Legal Issues</td>
<td>7</td>
</tr>
<tr>
<td>2.0</td>
<td>PREVIOUS REVIEWS AND REPORTS</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Royal Commission Into NSW Prisons (Nagle Report)</td>
<td>11</td>
</tr>
<tr>
<td>2.2</td>
<td>Women in Prison Task Force Report</td>
<td>15</td>
</tr>
<tr>
<td>2.3</td>
<td>Royal Commission into Aboriginal Deaths in Custody</td>
<td>16</td>
</tr>
<tr>
<td>2.4</td>
<td>Working Group - Transfer of Responsibility</td>
<td>17</td>
</tr>
<tr>
<td>2.5</td>
<td>Prison Health Management Board Report</td>
<td>18</td>
</tr>
<tr>
<td>2.6</td>
<td>Working Party on PMS Confidentiality Issues</td>
<td>18</td>
</tr>
<tr>
<td>2.7</td>
<td>Report by Independent Members of Parliament</td>
<td>18</td>
</tr>
<tr>
<td>2.8</td>
<td>Australian Law Reform Commission Report: Sentencing Prisoners</td>
<td>19</td>
</tr>
<tr>
<td>3.0</td>
<td>POPULATION SERVED BY THE PMS</td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Current Population</td>
<td>20</td>
</tr>
<tr>
<td>3.2</td>
<td>Future Population</td>
<td>20</td>
</tr>
<tr>
<td>4.0</td>
<td>HEALTH STATUS OF NSW PRISONERS</td>
<td></td>
</tr>
<tr>
<td>5.0</td>
<td>LOCATIONS SERVED BY THE PMS</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Gaols</td>
<td>24</td>
</tr>
<tr>
<td>5.2</td>
<td>Periodic Detention Centres</td>
<td>24</td>
</tr>
<tr>
<td>5.3</td>
<td>Physical Design of Gaols</td>
<td>25</td>
</tr>
<tr>
<td>6.0</td>
<td>ADMINISTRATIVE RESPONSIBILITY FOR THE PMS</td>
<td>26</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>7.0</td>
<td>ORGANISATIONAL STRUCTURE OF PMS</td>
<td></td>
</tr>
<tr>
<td>7.1</td>
<td>Current Structure of PMS</td>
<td>30</td>
</tr>
<tr>
<td>7.2</td>
<td>Importance of Accountability</td>
<td>30</td>
</tr>
<tr>
<td>7.3</td>
<td>Need for PMS Board of Management</td>
<td>31</td>
</tr>
<tr>
<td>7.4</td>
<td>Membership of Board</td>
<td>32</td>
</tr>
<tr>
<td>7.5</td>
<td>Sub-Committees</td>
<td>32</td>
</tr>
<tr>
<td>7.6</td>
<td>Role of Board in Planning and Monitoring</td>
<td>32</td>
</tr>
<tr>
<td>7.7</td>
<td>Cost of new Structure</td>
<td>33</td>
</tr>
<tr>
<td>7.8</td>
<td>Problems of Current Organisational Structure</td>
<td>33</td>
</tr>
<tr>
<td>7.9</td>
<td>Options for the Delivery of Health Services to Prisons</td>
<td>38</td>
</tr>
<tr>
<td>8.0</td>
<td>PMS BUDGET</td>
<td></td>
</tr>
<tr>
<td>8.1</td>
<td>Budget Allocation</td>
<td>42</td>
</tr>
<tr>
<td>8.2</td>
<td>Difficulties in Obtaining Information on PMS Budget and Activity</td>
<td>42</td>
</tr>
<tr>
<td>8.3</td>
<td>Calculating Appropriate Funding</td>
<td>43</td>
</tr>
<tr>
<td>9.0</td>
<td>NURSING SERVICES AND GAOL HEALTH TEAMS</td>
<td></td>
</tr>
<tr>
<td>9.1</td>
<td>Services Provided</td>
<td>48</td>
</tr>
<tr>
<td>9.2</td>
<td>A Note on the Situation of Prison Nurses</td>
<td>50</td>
</tr>
<tr>
<td>9.3</td>
<td>Problems with Nursing Services</td>
<td>50</td>
</tr>
<tr>
<td>9.4</td>
<td>Gaol Health Teams</td>
<td>52</td>
</tr>
<tr>
<td>10.0</td>
<td>GENERAL PRACTITIONER CLINICS AND SPECIALIST SERVICES</td>
<td></td>
</tr>
<tr>
<td>11.0</td>
<td>PSYCHIATRIC SERVICES</td>
<td></td>
</tr>
<tr>
<td>11.1</td>
<td>Problems in Service Delivery</td>
<td>55</td>
</tr>
<tr>
<td>11.2</td>
<td>Need for Training</td>
<td>56</td>
</tr>
<tr>
<td>11.3</td>
<td>Responsibility for Psychologists’ Services</td>
<td>60</td>
</tr>
<tr>
<td>12.0</td>
<td>HOSPITAL SERVICES</td>
<td></td>
</tr>
<tr>
<td>12.1</td>
<td>Long Bay Prison Hospital</td>
<td>62</td>
</tr>
<tr>
<td>12.2</td>
<td>Public Hospitals</td>
<td>62</td>
</tr>
<tr>
<td>13.0</td>
<td>HIV/AIDS SERVICES</td>
<td></td>
</tr>
<tr>
<td>13.1</td>
<td>Services Provided</td>
<td>65</td>
</tr>
<tr>
<td>13.2</td>
<td>Problems in HIV/AIDS Services</td>
<td>65</td>
</tr>
<tr>
<td>13.3</td>
<td>Preventive Measures</td>
<td>66</td>
</tr>
<tr>
<td>14.0</td>
<td>DENTAL SERVICES</td>
<td></td>
</tr>
<tr>
<td>14.1</td>
<td>Dental Health of Prisoners</td>
<td>68</td>
</tr>
<tr>
<td>14.2</td>
<td>International Standards</td>
<td>68</td>
</tr>
<tr>
<td>14.3</td>
<td>Standard and Level of Service</td>
<td>68</td>
</tr>
<tr>
<td>14.4</td>
<td>Responsibility for Dental Services</td>
<td>69</td>
</tr>
</tbody>
</table>
15.0 DRUG AND ALCOHOL PROGRAMS

16.0 STAFF EMPLOYED BY THE PMS
16.1 Executive Staff
16.2 Nursing Management
16.3 Nurses
16.4 Medical Officers
16.5 Administrative Services Staff
16.6 Dental Staff
16.7 Physiotherapists
16.8 Psychologists

17.0 STAFF TRAINING AND DEVELOPMENT
17.1 Courses Available
17.2 Problems in Training and Development
17.3 Responsibility for Staff Development and Study Leave
17.4 Training in Aboriginal Health Issues
17.5 Education in Relation to HIV/AIDS
17.6 Conclusion

18.0 GROUPS WITH SPECIFIC NEEDS
18.1 Women Prisoners
18.2 Aboriginal Prisoners
18.3 Drug Users in Custody
18.4 Older Prisoners
18.5 Prisoners with Intellectual Disabilities
18.6 Prisoners with HIV/AIDS
18.7 Prisoners of Non-English Speaking Background
18.8 Forensic Patients
18.9 Prisoners at Risk of Suicide
18.10 Juveniles

19.0 MEDICAL SERVICES TO ABORIGINAL PRISONERS
19.1 Services Provided to Aboriginal Prisoners by PMS
19.2 Services Provided by Aboriginal Medical Service (AMS)
19.3 Royal Commission Into Aboriginal Deaths in Custody
   - Interim Report
19.4 Royal Commission Into Aboriginal Deaths in Custody
   - Final Report
20.0 THE PRISON METHADONE PROGRAM
20.1 Prison Methadone Programs in Other States
20.2 Background to the NSW Program
20.3 Rationale for the Program
20.4 Risk Taking Behaviour in Gaols
20.5 Level of HIV Infection in Gaols
20.6 Administration of the Program
20.7 Involvement of Other PMS Staff
20.8 Evaluation of the Prison Methadone Program
20.9 Problems with the Prison Methadone Program
20.10 Conclusion

21.0 RECEPTION, ASSESSMENT AND HEALTH SCREENING OF PRISONERS
21.1 Need for Adequate Reception Procedures
21.2 Procedure in NSW
21.3 Procedure in Victoria
21.4 Transfer of Information
21.5 Need for Data Collection

22.0 MEDICAL RECORDS
22.1 Storage
22.2 Access to Prisoners’ Records
22.3 Security
22.4 Problems with Record System

23.0 ROLE OF THE PRISON MEDICAL SERVICE IN PREVENTIVE HEALTH CARE

24.0 QUALITY ASSURANCE

25.0 ROLE OF THE COMMONWEALTH
25.1 Custodial Role
25.2 Health Role

26.0 COMPLAINTS BY PRISONERS

27.0 OUTSTANDING ISSUES

28.0 VIEWS ABOUT THE PMS
28.1 Nurses’ views
28.2 Superintendents’ views
28.3 Inmates’ Views
APPENDICES

APPENDIX A - Submissions Received 140

APPENDIX B - Meetings Held 141

APPENDIX C - United Nations - Standard Minimum Rules for the Treatment of Prisoners 142

APPENDIX D - Gaols Served by the PMS 144

APPENDIX E - Recommendations of Royal Commission Into Aboriginal Deaths in Custody - Final Report, May 1991 146

APPENDIX F - Briefing Paper Prepared by Directorate of Drug Offensive 150

APPENDIX G - Reception Assessment Sheet
PART ONE:

THE CARE PROVIDED BY THE PRISON MEDICAL SERVICE
TO PERSONS DETAINED IN DEPARTMENT OF CORRECTIVE SERVICES
INSTITUTIONS
CHAPTER 1

1.0 INTRODUCTION

1.1 The Need for a Review of the Prison Medical Service

The Committee to review the Prison Medical Service was established by the Minister for Health, the Hon. P.E.J. Collins, M.P., in 1990. The establishment of the Committee provided the first opportunity for a comprehensive and independent review of the Service.

The Minister's decision to establish the Committee was largely as a result of the findings of official enquiries. In 1988, the Interim Report of the Royal Commission Into Aboriginal Deaths In Custody made a number of recommendations concerning the Prison Medical Service. The Commission's reports of inquiry into the deaths of Thomas Murray, who died in 1983 at Bowral Hospital after transfer from Berrima Gaol, and Malcolm Smith, who died at Long Bay Gaol in 1983, contained severe criticisms of the PMS. Following the Royal Commission's Interim Report, an Inter-Departmental Committee was established at the Premier's direction. That Committee itself produced an interim report in October 1988 which summarised the concerns of the Royal Commission. It commented:

"It is understood that there have been major increases in spending in the Prison Medical Service and that services have been expanded. Whilst these improvements are acknowledged the Committee has not examined the Prison Medical Service in detail. However, given the difficulties indicated by the Royal Commission and the important role the Prison Medical Service can play in reducing the risk of death in custody, there exists a need to urgently review the service provided by the Prison Medical Service to assess its adequacy and to assess the resources made available to it".  

The issue of resources has become increasingly significant in recent times as the prison population has expanded very quickly. In addition the number of services taken on by the PMS has been increasing. The introduction of compulsory HIV testing, the assumption of responsibility for the Methadone Program and the growth in the number of prisoners means that more demands are being made of the Service. More recently, the PMS has assumed some responsibility for providing medical services to young people in juvenile justice institutions.

1.2 Methodology for the Review

A number of strategies were adopted by the Committee in conducting the review and compiling the report. They were aimed at collecting and analysing information from a variety of sources, and included:

- Collection and analysis of local, interstate and overseas published material.
- Advising key individuals of the terms of reference for the review, and requesting comments and submissions from them. (See Appendix A for a list
of submissions received).
- Meeting with interested and affected individuals, including Senior Officers of the Department of Health and the Department of Corrective Services. (See Appendix B for a list of meetings held)
- Holding extensive discussions with the Director and Deputy Director of the PMS, with the Director, Deputy Director and Assistant Directors of Nursing for the PMS, and with Career Medical Officers, nurses and other PMS staff.
- Visits to a number of Custodial Institutions, including:
  - Gaols in the Long Bay Complex
  - Goulburn Gaol
  - Berrima Gaol
  - Bathurst Gaol
  - Oberon Afforestation Camp
  - Mulawa Training and Detention Centre
  - Pentridge Gaol (Victoria)
  - Fairlea Women’s Prison (Victoria).
- Distribution of surveys to nurses in the PMS, to Superintendents of Gaols and to inmates.
- Commissioning a consultancy to examine nursing services in the PMS. This consultancy was conducted by Ms Bernie Closs, Department of Psychiatric Nursing, Victoria College, Melbourne.
- Examination of files relating to complaints made by prisoners to the Complaints Unit of the NSW Department of Health.
- Commissioning a consultancy to comment on organisational and administrative aspects of the PMS. This consultancy was conducted by Mr Peter Lloyd, Lecturer, School of Public Health, University of Sydney.
- Requesting the preparation by the Directorate of the Drug Offensive of a Briefing Paper on the Prison Methadone Program.

In addition, members of the Committee had many informal discussions with nurses, Superintendents and staff of the Department of Health, Corrective Services and Family and Community Services.

1.3 Role of the Prison Medical Service

The Prison Medical Service (PMS) provides a system of health care to inmates of NSW gaols. Most of this health care is provided by medical and nursing staff situated at the gaols. The PMS has also recently assumed a role in providing medical services to young people detained in juvenile justice institutions.

The PMS is similar in some respects to other organisations providing medical services (such as public hospitals) but there are a number of significant differences:

- the population served by the service is institutionalised, geographically dispersed, and on the whole, drawn from the lower socio-economic groups of society
Aboriginal people are disproportionately represented in the population\(^{(2)}\),

although most of the prison population is comprised of young men, it appears
that the overall morbidity rate of inmates on entry to gaol is high

the service has responsibility for providing all dental care to inmates

there is limited access for inmates to non-medical alternatives

the service operates in physical surroundings controlled by Custodial (as
opposed to Health) staff, and mandatory security requirements and detailed
procedures affect all situations, including health care

the custodial environment creates additional stresses for both inmates and staff

services to inmates (including those on remand) do not attract Medicare
funding from the Commonwealth.

1.4 History of the PMS

In England, the Prison Medical Service started around 1774, largely to prevent typhus
spreading from prisons to surrounding communities.\(^{(3)}\) In NSW, the PMS had its
origin with the First Fleet, but until 1914, there was no distinct medical service for
prisoners. Long Bay Gaol was proclaimed as a prison on 1 June, 1914 and in that
year, a Medical Officer was employed on a part-time basis to manage the health care
of inmates at Long Bay. The gaol accommodated both male and female prisoners, and
had a total of 38 hospital beds. Two prison officers, neither of whom had any
medical or nursing training, assisted the Medical Officer. In 1951, the first full-time
Medical Officer was appointed at Long Bay, and in 1953 the first registered nurse was
employed. In other gaols, medical services were provided by visiting medical officers.

Until 1968, nursing staff were employed by the Department of Prisons, and wore the
same uniforms as custodial staff. In July 1968, the responsibility for health care of
inmates was transferred to what is now the Department of Health. Long Bay Prison
Hospital opened in May 1987.

The PMS has changed greatly over recent years. The introduction of a Methadone
program in NSW gaols, the spread of HIV/AIDS in the community and large increases
in the prison population have had a significant impact on the PMS and its work.
1.5 International Standards - Medical Care in Custodial Institutions

Of fundamental importance to the Prison Medical Service is the principle embodied in international law that prisoners are entitled to the same level of medical care as that received by the rest of the community. This principle is embodied in Principle 1 in the Annexure to Resolution 37/194 of the UN General Assembly adopted in late 1982, and has since been restated in many reports and reviews of the Prison Medical Service. This principle is stated to be an objective of the NSW PMS.\(^{(5)}\)

Other international instruments provide detailed standards to be observed in relation to the detention of prisoners.\(^{(5)}\) These rules are reproduced in Appendix C. It is important to note that they provide for minimum standards only. They cover a number of important areas, including accommodation, personal hygiene, food and exercise. However they also deal specifically with medical services, stating that:

- a qualified medical officer with some knowledge of psychiatry should be available at every institution

- that hospital facilities in institutions should be "proper for the medical care and treatment of sick prisoners"

- the services of a qualified dental officer should be available to every prisoner

- in women’s institutions, special accommodation for all necessary pre natal and post natal care and treatment should be available.

It should also be noted that international standards referred to above distinguish between "untried" and "sentenced" prisoners and provide, generally, that a higher standard of care should be provided to prisoners not yet sentenced. This is consistent with the principle that untried prisoners are innocent in the eyes of the law. This distinction is particularly relevant in NSW, where in the first 6 months of 1990, 23.6% of the prison population was on remand.\(^{(6)}\)

1.6 Statutory Background

The following is a summary of some of the main legislative provisions affecting the establishment, operation and duties of the Prison Medical Service.

The Prison Medical Service is the only remaining organisation established as a Fifth Schedule Hospital (a hospital conducted by the Minister) under section 29 IA of the Public Hospitals Act, 1929. This provision places the Prison Medical Service within the Department of Health’s organisational structure, responsible to and accountable to the Director-General of the Department of Health.

Statutory recognition is given in the Prisons Act 1952 to the position of "medical officer" and the Governor is given a power of appointment of one or more medical officers for each prison (s.9(1)). Such an appointment must be made upon the recommendation of the Minister for Health, and with the concurrence of the Minister.
for Corrective Services.

Section 16 of the Prisons Act 1952 sets out the statutory entitlement of prisoners to medical attention. It provides that:

16. (1) Every prisoner shall be supplied with such medical attendance, treatment and medicine as in the opinion of a medical officer is necessary for the preservation of the health of the prisoner and of other prisoners and of prison officers, and may be so supplied with such medical attendance, treatment and medicine as in the opinion of the Director-General will alleviate or remedy any congenital or chronic condition which may be a hindrance to rehabilitation.

(2) Where in the opinion of a medical officer the life or health of a prisoner is likely to be endangered or seriously prejudiced by the failure of such prisoner to undergo medical treatment or the life or health of any other prisoner or prison officer is likely to be endangered or seriously prejudiced by such failure, the prisoner may be compelled to submit to such medical treatment as is ordered by a medical officer.

(3) Medical attention as required by this section is to be supplied (except to the extent that provision is otherwise made by an agreement in force under Part 6A) at the public expense.

Part 6A allows for contractors to be engaged to assist the Director-General in the exercise of functions under the Prison Act, as will be required for the operation of the new private gaol at Junee.

In the judgment of the NSW court of Appeal in Rv Tanzir Danhach (Unreported, 12 August 1977) his Honour Chief Justice Street stated:

"persons in prisons ... clearly are not free to seek medical advice of their own choosing or at their own will. This imports upon the prison authorities the obligation of ensuring that adequate medical advice and treatment is made available. Proper care of the health of inmates in the prison system is a significant part of the responsibilities of the prison authorities".

Section 50(1) of the Prisons Act provides that the Governor may make regulations with respect to:

(1) all matters necessary or expedient for the good order, discipline and health of prisoners.

The Prisons (General) Regulation 1989 provides:

53 (1) Dental treatment, optical treatment and hearing aids and other artificial medical appliances are to be supplied to prisoners in such manner and to such extent as the Director of the Prison Medical
Service shall from time to time determine.

(2) Subclause (1) does not apply in any circumstances in which section 16 of the Act applies.

The Prisons (Administration) Regulation 1989 provides for such matters as duties of Prison Medical Officers, examination of prisoners, prisoners at risk or a risk to others, prisoners with special needs, medical history cards, infectious diseases and death of prisoners.

The Health Administration Act 1982 prohibits the disclosure of information "obtained in connection with the administration or execution of this Act or any other Act" except in certain circumstances (s.22). The Mental Health Act 1990 contains a similar provision (s.289).

Actions and claims for damages against staff working under the Prisons Act 1952 are severely limited by section 46 of that Act which provides:

No action or claim for damages shall lie against any person for or on account of anything done or commanded to be done by him and purporting to be done for the purpose of carrying out the provisions of this Act, unless it is proved that such an act was done or commanded to be done maliciously and without reasonable and probable cause.

This is consistent with recent views which limited the rights of prisoners to sue: "capital felons" and possibly other felons in most States of Australia were until recently denied the right to initiate civil actions of any kind in the courts. Restrictions on civil actions by prisoners were however removed to a large extent in NSW by the Felons (Civil Proceedings) Act 1981.

1.7 Legal Issues

A number of legal issues relevant to the operation of the PMS were raised in submissions to the Committee. These issues included:

(i) the terms of section 16 of the Prisons Act;

(ii) accountability and responsibility of medical officers;

(iii) administrative responsibility for regulations;

(iv) inconsistencies in regulations;

(v) incorporation of minimum standards into legislation.

Although these issues are not strictly within the Committees terms of reference, the Committee believes they raise important questions. The Committee is grateful to the Prisoner's Legal Service Advisory Committee of the Legal Aid Commission, and Mr
John Basten of Frederick Jordan Chambers for their comprehensive submissions on these matters.

Section 16(2) of the Prisons Act provides:

"where in the opinion of a medical officer the life or health of a prisoner is likely to be endangered or seriously prejudiced by the failure of such prisoner to undergo medical treatment or the life or health of any other prisoner or prison officer is likely to be endangered or seriously prejudiced by such failure, the prisoner may be compelled to submit to such medical treatment as is ordered by a medical officer."

Justice Nagle commented in 1975 that the powers given to the medical officer under s.16(2) are:

"extraordinary.....they would enable him to compel any prisoner, for example, to undergo even a lobotomy if he felt that the prisoner endangered another prisoner. This.....clearly requires further consideration."

This section was considered in the decision of Schneidas v Corrective Services Commission where the Supreme Court ruled that the section permitted a prisoner to be force-fed while on a hunger strike.

Section 574B of the Crimes Act, enacted after that decision, provides that it is lawful to use "such force as may reasonably be necessary to prevent the suicide of another person". While this latter provision would arguably cover the situation in Schneidas, the application of section 16(2) is considerably wider. The Committee is concerned at the extraordinarily broad powers which this section gives to the medical officer.

This section can be contrasted with those in the Mental Health Act 1990 governing invasive medical procedures such as psychosurgery and electro-convulsive therapy. That Act gives a range of protections to patients (including temporary patients, continued treatment patients, forensic patients or any other person under detention in a hospital) and provides that stringent conditions must be satisfied before medical practitioners are permitted to perform certain procedures. Under that Act, persons convicted of any crime are presumed incapable of giving consent. Medical officers proposing to perform psychosurgery must apply to the Psychosurgery Review Board. Before electro-convulsive therapy is undertaken, two medical practitioners (one of whom must be a psychiatrist) must certify that the treatment is a reasonable and proper treatment for the person to have and that it is necessary or desirable for the safety or welfare of the person.

The Victorian Corrections Act 1986 states:

47(1) Every prisoner has the following rights:

(f) the right to have access to reasonable medical care and treatment necessary for the preservation of health, including, with the approval of the principal medical
officer but at the prisoners own expense, a private medical practitioner, physiotherapist or chiropractor chosen by the prison.

(g) if intellectually disabled or mentally ill, the right to have reasonable access within the prison or, with the Government's approval outside a prison to such special care and treatment as the medical officer considers necessary or desirable in the circumstances.

(h) the right to have access to reasonable dental treatment necessary for the preservation of dental health.

It should be noted that the Act contains no coercive power such as that in section 16(2) of the NSW legislation.

Ward A and some areas of Ward C of the Prison Hospital have been gazetted as a hospital under the Mental Health Act, and those gazetted areas are subject to the Act's provisions. Most prisoners are not affected by the Act.

The Committee believes that prisoners should not be deprived of rights which are available to the community at large unless some specific circumstance relating to their incarceration demands such deprivation. International concern has been raised on numerous occasions in relation to actual or alleged experimentation involving prisoners, partly on the basis that prisoners are less able to resist invitations to become part of a medical experiment and may be promised privileges if they do so. In addition, the circumstances in which treatment may be refused by a prisoner may arise from political or religious conviction.

The Committee is not convinced that there is need for a medical officer to have the extensive powers which exist in section 16(2). There will generally be alternative means of dealing with the situation of a prisoner suffering from some complaint which may harm others, or harm himself or herself. If a case can be made out for the existence of such powers in some circumstances then the right should be strictly limited to such cases.

Section 16(2) makes no mention of who may compel the prisoner to submit to treatment. There is no requirement that it be provided by a medical officer, but only that a medical officer of the prison hold a particular opinion. This ambiguity about who may be authorised to act on the medical officer's opinion may give rise to difficult questions about the lawfulness of conduct undertaken, particularly where the treatment is undertaken by someone other than a prison medical officer and where the precise treatment has not been expressly stated or stated in writing by a medical officer.

Responsibilities of a medical officer for a prisoner are defined in s.16 of the Act and spelled out in further detail in regulations to the Prisons Act, such as the Prisons (General) Regulation and the Prisons (Administration) Regulation. This means that the PMS is governed by regulations made at the behest of the Minister for Corrective Services.
As these issues fall outside the Committee's terms of reference, no recommendations have been made. It should be noted however that the Committee has serious concerns about these matters.

In Chapter 7 of this report, the organisation and administration of the Prison Medical Service is discussed, and recommendations are made for a new administrative structure for the Service.

The Committee understands that there are a number of options which would allow such a restructuring to be achieved at a formal level. They include the use of administrative mechanisms under existing legislation, and the enactment of a separate Prison Medical Service Act. The Committee was not able to fully investigate these options but believes that they should be considered in detail by the Legal Branch of the Department of Health. At that time, it would be appropriate for the other legal issues referred to above to be addressed.

RECOMMENDATION

1. That the principle of equality of service with that of the general community be reaffirmed as the guiding principle for health care in prisons.

FOOTNOTES

(1) The Inter-Departmental Committee on Aboriginal Deaths in Custody - Review of Police and Department of Corrective Services Custodial Procedures p.36.


(6) Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice, No.27, Remand Imprisonment in Australia.


(8) Unreported, Lee J., 8 April 1983.
2.0 PREVIOUS REVIEWS AND REPORTS

In recent years there have been a number of reviews dealing with issues relevant to gaols. On occasions prison medical services have been considered incidentally in these reviews but there has never been any independent, systematic or comprehensive review of the Prison Medical Service alone.

The following is a summary of some of these previous reports, and refers to some of the main recommendations made. It will be observed that there are a number of "themes" which occur in the recommendations.

2.1 Royal Commission Into NSW Prisons (Nagle Report)

Following riots at Bathurst Gaol in 1974, the Royal Commission into NSW Prisons was established, and issued its report in March 1978.\(^1\)

Justice Nagle stressed in the Report that the standard of care provided to prisoners should be equal to that available to other members of the community, a principle which is consistent with U.N. Standards and which is supported by the PMS.

This report was an indictment of the gaol regime which existed at that time. Medical services in prisons were considered in Chapter 24. It referred to the 1975/76 Annual Report for the Department of Corrective Services which claimed that "a comprehensive range of medical, psychiatric and dental care have continued to be provided" to prisoners. The 1976/77 Annual Report similarly stated that the PMS was "responsible for meeting the health needs of adult individuals in custody in the State's correctional institutions" and made exactly the same statement about the comprehensiveness of medical care provided. Justice Nagle concluded that medical services "could not be described in the glowing terms used by the Department of Corrective Services", and made sixteen recommendations specifically relating to medical services. Other chapters dealt with medical issues as parts of other themes: for example, Chapter 27, dealing with women prisoners made at least four recommendations about medical services provided to these women. Chapter 29 dealt with "Governor's Pleasure" prisoners and four recommendations were made.

In this report Mr Justice Nagle examined section 16 of the Prisons Act, which provides the statutory entitlement of prisoners to medical attention. He recommended that section 16(1) should be amended to place the responsibility for determining the necessity for medical treatment entirely upon the medical officer. He also commented that the powers given to the medical officer under s.16(2) are:

"extraordinary .... they would enable him to compel any prisoner, for example, to undergo even a lobotomy if he felt that the prisoner endangered another prisoner. This was not raised as an issue before the Commission but clearly requires further consideration".
He recommended that consideration should be given to the extent of the medical officer's powers under this section.

The following table sets out the recommendations of the Nagle Royal Commission which were relevant to the Prison Medical Service and the Committee's terms of reference, and the Committee's understanding as to the implementation of each recommendation. It should be noted that although it is possible to easily assess whether or not some recommendations have been implemented, others are more problematic. It is for example, difficult to assess objectively whether "adequate" medical advice and treatment is available to all prisoners, or whether the level and extent of detoxification programs are satisfactory.
<table>
<thead>
<tr>
<th>RECOMMENDATIONS</th>
<th>IMPLEMENTED?</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate medical advice and treatment to be available to all prisoners.</td>
<td>Difficult to assess</td>
<td></td>
</tr>
<tr>
<td>Health (Commission) to continue to provide staff to PMS.</td>
<td>Yes</td>
<td>See Chapter 6</td>
</tr>
<tr>
<td>Prison Commission to be responsible for ensuring prisoners receive proper treatment.</td>
<td>No</td>
<td>Prison Commission no longer operative.</td>
</tr>
<tr>
<td>Senior officer of DOCS to have overall responsibility for medical and psychiatric services.</td>
<td>Yes</td>
<td>Nominal responsibility only.</td>
</tr>
<tr>
<td>Part-time medical officers in gaols to serve no longer than 5 years.</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Selected prison officers to undergo elementary medical training to assist PMS staff.</td>
<td>No</td>
<td>Some first aid training provided to new prison officers.</td>
</tr>
<tr>
<td>Section 16(1) Prisons Act to be amended to place responsibility for determining necessity for medical treatment on medical officer.</td>
<td>No</td>
<td>See Chapter 1.</td>
</tr>
<tr>
<td>Consideration be given to changing s.16(2) Prisons Act.</td>
<td>No</td>
<td>See Chapter 1.</td>
</tr>
<tr>
<td>Responsibility for determining necessity for dental and optical treatment, hearing aids and other medical appliances to be with appropriate officer of PMS.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Test for provision of medical and other health care to be whether necessary for health of prisoner.</td>
<td>No</td>
<td>Complied with to varying extent.</td>
</tr>
<tr>
<td>Prisoners should receive same medical and health care as private citizens.</td>
<td>No</td>
<td>Complied with to varying extent.</td>
</tr>
<tr>
<td>RECOMMENDATIONS</td>
<td>IMPLEMENTED?</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Proper medical examination and assessment to be conducted of prisoners on reception.</td>
<td>No</td>
<td>Limited - See Chapter 21.</td>
</tr>
<tr>
<td>Screening procedures to be established to identify drug users, on admission and during imprisonment.</td>
<td>Yes</td>
<td>See Chapter 21.</td>
</tr>
<tr>
<td>Detoxification treatment to be provided for drug addicts; continuing treatment program to be established.</td>
<td>Yes</td>
<td>Adequacy can be questioned.</td>
</tr>
<tr>
<td>Observation section of Malabar Complex to be closed.</td>
<td>Yes</td>
<td>Closed in 1984</td>
</tr>
<tr>
<td>Overall assessment of PMS to be conducted by outside medical expert.</td>
<td>Yes</td>
<td>PMS Review Committee includes medical expertise.</td>
</tr>
<tr>
<td>Immediate improvement to be made to medical services at Mulawa.</td>
<td>Yes</td>
<td>Extent of improvement difficult to assess.</td>
</tr>
<tr>
<td>No further admissions of psychiatrically disturbed women to be made to Mulawa.</td>
<td>No</td>
<td>See Chapter 11.</td>
</tr>
<tr>
<td>Ante-natal and gynaecological treatment to be available to all women prisoners.</td>
<td>Yes</td>
<td>Adequacy can be questioned.</td>
</tr>
<tr>
<td>Over-sedation of women prisoners to cease.</td>
<td>Difficult to assess.</td>
<td></td>
</tr>
</tbody>
</table>

Of the Nagle Report’s recommendations which have not been implemented, the Committee has particular concerns about:

- section 16 of the Prisons Act.
- continued admission of psychiatrically disturbed women to Mulawa.
- medical examination and assessment of prisoners on reception.

These are discussed in Chapters 1, 11, and 21.
2.2 Women in Prison Task Force Report

The Report of the NSW Women in Prison Task Force was issued in 1985. Its chapter on medical and dental care commented:

"the inadequacy of health-care services to women prisoners in NSW formed the basis of criticisms made by the Nagle Royal Commission and it would appear that, regrettably, little has changed since that time".

This chapter commented on the conflict between custodial and health care requirements, and referred to widespread dissatisfaction with the provision of health services expressed by women prisoners. In particular, such complaints included:

- harsh and uncaring attitudes (to prisoners by medical staff)
- excessive concern with prison ethics (by medical staff)
- unsatisfactory treatment of minor medical ailments and all dental problems
- difficulty in having minor ailments diagnosed and treated
- delays in treatment
- difficulty in getting "outside" referrals and escorts
- concerns about confidentiality.

The report set out a number of principles which it believed should form the basis of its recommendations. It made a major recommendation relating to health care, which was:

"That the government establish a pilot program in women's prisons to replace the existing centralised Prison Medical Service delivery model. The pilot program would involve placing responsibility for health and dental care with regional Health Department bodies, supplemented with preventative services by appropriate community organisations".

Pending implementation of the above recommendation, the Task Force considered that 11 other recommendations should be implemented immediately. They covered:

- retention of rights to Medicare coverage by prisoners
- right to doctor of choice, to choose male/female doctor, to obtain second opinions and to have specialist consultations without delay
- preservation of confidentiality
- access to preventative care
separate detoxification unit at Mulawa
reorganisation of accommodation at Mulawa
treatment of pregnant prisoners
regular evaluation of dental services
time for attendance of doctors
training of custodial staff.

N.B. A Minority Report was submitted to the then Minister (the Hon. Mr John Akister) by some members of the Task Force, in respect of three issues. Those issues did not concern medical services, and the dissenting members stressed that they supported the remaining recommendations of the majority report.

Few, if any, of the Task Force recommendations have been implemented. Strong criticisms of services to women prisoners continue to be made by interested groups.²

2.3 Royal Commission Into Aboriginal Deaths in Custody

In 1988 the Interim Report of the Royal Commission into Aboriginal Deaths in Custody was issued by Mr Justice Muirhead.³ The Commission's Reports of Inquiry into the deaths of Thomas Murray (who died on 21 December 1983 at Bowral Hospital after being transferred from Berrima gaol) and Malcolm Smith (who died at Long Bay Gaol on 5 January 1983) contained quite severe criticisms of the PMS. Chapter 9 of the Interim Report considered medical issues.

Relevant recommendations made in that report included:

- that comprehensive medical histories for prisoners be obtained
- that the PMS be independent of the Department of Corrective Services
- that there be twenty four hour access to medical practitioners
- that there be instructions encouraging prison/police officers to seek medical attention for detainees
- that resuscitation equipment be available at prisons
- that there be consultation between Corrective Services, the PMS and Aboriginal Medical Services.

Following the Interim Report of Mr. Justice Muirhead, an Inter-Departmental Committee on Aboriginal Deaths in Custody was established at the direction of the Premier. It was required to:
monitor problems arising in connection with the detention of persons in custody and to recommend remedial steps

- review the Corrective Services jurisdiction by assessing existing custodial procedures and taking appropriate measures to resolve any issue of concern

- consider the Interim Report of the Royal Commission into Aboriginal Deaths in Custody.

This Committee produced an interim report in October 1988 which summarised the concerns of the Royal Commission and formulated its own recommendations. It commented:

"It is understood that there have been major increases in spending in the Prison Medical Service and that services have been expanded. Whilst these improvements are acknowledged the committee has not examined the Prison Medical Service in detail. However, given the difficulties indicated by the Royal Commission and the important role the Prison Medical Service can play in reducing the risk of death in custody, there exists a need to urgently review the service provided by the Prison Medical Service to assess its adequacy and to assess the resources made available to it." 

This comment was one of the factors leading to the formation of the current Committee. The inter-departmental committee however, continues to monitor the implementation of the Royal Commission’s recommendations. Other reports were issued as a result of this monitoring and implementation process.

In relation to other recommendations of the Royal Commission, it can be observed that the PMS remains independent of the Department of Corrective Services. The Committee understands that instructions have been issued encouraging police and prison officers to seek medical attention for detainees, and that there is on-going but irregular consultation between DOCS, the PMS and Aboriginal medical services.

The final report of the Royal Commission into Aboriginal Deaths in Custody was issued in May 1990. Recommendations relevant to the Prison Medical Service are discussed in Chapter 19.

2.4 Working Group - Transfer of Responsibility

In 1988 the Minister for Health requested that a Working Group of Officers from the Departments of Health and Corrective Services consider the question of transferring responsibility for the PMS to the Corrective Services Portfolio. The Report was issued in October 1988 and concluded that the Minister for Health should be advised that on balance it was preferable to retain responsibility for the PMS within the Health portfolio.
2.5 Prison Health Management Board Report

By agreement between the Ministers for Health and Corrective Services, a Prisons Health Management Board was established in 1988 under the Chairmanship of Mr Justice Perrignon. The terms of reference of the Board were:

(a) to supervise and monitor the provision of all health care services to prisoners in NSW gaols, ensuring compliance where possible with relevant national and international standards.

(b) to develop and implement strategies for illness prevention and the attainment of a healthy lifestyle for prisoners.

(c) to advise the Minister for Health and the Minister for Corrective Services on the adequacy of resources and service provision and make recommendations where necessary.

On 26 March 1990, Justice Perrignon issued a brief confidential report to the Minister.

2.6 Working Party on PMS Confidentiality Issues

This Working Party was established in January 1988 at the request of the Minister for Health following correspondence from the Minister for Corrective Services. The Working Party reported on 4 August 1988 and recommended amendments to the Mental Health Act 1983 and the Health Administration Act 1982, so as to allow information to be passed between the PMS and Corrective Services.

The Prisons (Administration) Regulation 1989 contains specific provisions governing such matters as medical history cards for prisoners. It therefore addresses some of the issues raised by the Royal Commission into Aboriginal Deaths in Custody.

2.7 Report by Independent Members of Parliament

Following the implementation of the policy restricting personal property of inmates in NSW gaols, concern was expressed by four independent members of the NSW Parliament about events and conditions in NSW gaols. These four members (Robyn Read, MP, Elizabeth Kirkby, MLC, Dawn Fraser, MP and John Hatton, MP) obtained approval from the Minister for Corrective Services to visit Goulburn, Parklea and Bathurst Gaols, and conducted visits to these gaols in October 1990. A report was prepared by Ms Robyn Read, MP, on behalf of the group.

The report was unable to review health services in any detail, but recommended:

- that funding to educational, health and employment programs be substantially increased
- that compulsory HIV testing be deferred.
It also referred to concerns about monitoring of dosages for prisoners on psychotropic drugs, and about the lack of counselling in relation to AIDS testing.

2.8 Australian Law Reform Commission Report: Sentencing Prisoners

This discussion paper (No. 31, 1987) stated "the inadequacy of medical services provided at some prisons heightens the need for prisoners to be able to consult with private health personnel". Prisoners, however, would generally be unable to afford the costs of such private health care, even if prison authorities were to allow it, because prisoners are not covered by Medicare. The Commission stated:

"to ensure that all prisoners throughout Australia can receive adequate health care the effects of section 19(2) of the Commonwealth Health Insurance Act should be altered. It is tentatively recommended that the Minister for Health issue a direction to the effect that all prisoners are covered by Medicare, to the same extent as members of the community, for medical costs incurred for treatment other than by prison medical officers."

This is further discussed in Chapter 25.

FOOTNOTES


(3) Royal Commission Into Aboriginal Deaths in Custody, Interim Report, AGPS, Canberra.

(4) The Inter-Departmental Committee on Aboriginal Deaths in Custody - Review of Police and Department of Corrective Services Custodial Procedures, p.36.
CHAPTER 3

3.0 POPULATION SERVED BY THE PMS

3.1 Current Population

In the NSW gaol system, prisoners are continually being received and discharged. There are therefore difficulties in obtaining accurate statistics for prison populations, as numbers change daily.

The following numbers supplied by the Department of Corrective Services relate to the average number of inmates (both sentenced and unsentenced) for the financial years listed. Numbers for periodic detainees (as distinct from prisoners in full-time custody) are given separately as they are only in custody over each weekend.

Average Numbers of Inmates

<table>
<thead>
<tr>
<th></th>
<th>Full-time</th>
<th>Periodic Detention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989/90</td>
<td>5002</td>
<td>684</td>
<td>5,686</td>
</tr>
<tr>
<td>1988/89</td>
<td>4358</td>
<td>509</td>
<td>4,867</td>
</tr>
<tr>
<td>1987/88</td>
<td>4124</td>
<td>400</td>
<td>4,524</td>
</tr>
<tr>
<td>1986/87</td>
<td>3971</td>
<td>323</td>
<td>4,294</td>
</tr>
<tr>
<td>1985/86</td>
<td>3854</td>
<td>304</td>
<td>4,158</td>
</tr>
</tbody>
</table>

It should be noted that there may be significant variation between the average and the actual number of inmates on any given day. For example, a census of the prison population conducted on 30 June 1990 which included prisoners subject to Periodic Detention, found that there were 6,367 prisoners. Of this 6,367, the following observations can be made:

- only 385 (6.05%) were female
- 921 (14.5%) were of non-English speaking background
- 579 (9.1%) identified themselves as Aboriginal
- 31.4% of the population was under 25 and 84.2% was under 40.

The Research Division of the Department of Corrective Services has advised the Committee that it does not keep figures for the number of prisoners "passing through" gaols in any given year. However a number of individuals separately advised the Committee that they estimated this figure to be about 20,000. This figure has significant implications for the demands on the PMS, particularly in relation to reception, assessment and screening.

3.2 Future Population

It should be noted that over the last two years, the prison population has increased by approximately 50%. This increase is due to a number of factors, including the passage of the Sentencing Act 1989 which abolished remissions and provides that
prisoners must serve at least 75 per cent of their sentence before becoming eligible for parole.

It is difficult to make accurate predictions as to future numbers of prisoners. Factors such as the arrest rate for different offences, the number of courts operating, whether maximum sentences are imposed, and changes in legislation all contribute to the number of inmates held. It is predicted that if numbers increase at the current rate, there will be 6,500 prisoners by the end of June 1992.\(^{(2)}\) Some indications are however that the rate of increase is likely to grow. Certainly it is predicted by senior officers of the DOCS that the gaol population is likely to number at least 8,000 by the end of the century. The population of Periodic Detention Centres is also predicted to increase at a faster rate than that of gaols for prisoners in full-time custody. This prediction is borne out by recent figures; the population for PDCs at 30 June 1990 was 600; for 31 December 1990 it was 1018.

The growth in the prison population will inevitably result in increased demands for health services.

**FOOTNOTES**

(1) Department of Corrective Services, Research and Statistics Division.

(2) ibid.
CHAPTER 4

4.0 THE HEALTH STATUS OF NSW PRISONERS

The Committee was unable to locate any scientifically valid epidemiological surveys of the health of inmates of NSW custodial institutions. Overseas literature stresses that the health profile of inmates does not match that of the general population.

For instance, Dr T.W. Harding states that although the health problems concerned with old age are under-represented in prisons, (the majority of the prison population is made up of young men), the overall morbidity rate on entry is strikingly high.\(^{(3)}\) A 1977 U.S. study quoted by Harding\(^{(2)}\) found that the most frequent problem identified at entry to gaol was substance abuse and dependence (illicit drugs 41%; alcohol 18%). Only 40% of prisoners were found to be in good health. Recent trauma was found in 17% of the prisoners, serious dental problems in 18%, eye abnormalities in 7%, and skin abnormalities in 46%. Psychiatric morbidity was also high, with 13% of the sample suffering from an active psychiatric disorder.

Harding goes on to say that experience suggests that high levels of morbidity on entry are generally observed in other prison populations. This is related to the fact that prisoners, as a whole, come from underprivileged social groups; their anti-social behaviour may be an expression of psychological problems (such as substance abuse and mental illness) and their life styles may interfere with normal health care. He states that there are also pathogenic factors within the prison environment:

(a) psychological stress
(b) overcrowding and poor sanitation
(c) unhealthy life styles
(d) intentional harm to self

It is highly likely that these factors exist in NSW.

There have been very few epidemiological studies in Australia addressing the impact of prison on health. An exception is the research conducted in 1985 by the Department of Corrective Services for the Women in Prison Task Force Report\(^{(3)}\) which found that before coming to prison, 45% of women reported suffering from health problems which required regular medical attention. 75% of the women reported having received medical treatment for health problems during their current period of imprisonment. The needs of women prisoners obviously vary from those of male inmates, so the result can only have limited applicability.

The Committee is aware of two other limited studies: one established that prison death rates, psychiatric committals and suicides increased in direct relation to the level of overcrowding, and that prisoners over 50 years of age were particularly susceptible.\(^{(4)}\)

Another established that life expectancy was reduced by 5 to 7½ years for people who had experienced prisons. However this study was limited, in that it was retrospective,
looked at male caucasians only, and was conducted in the 1930's.\(^5\)

The Committee surveyed inmates in NSW to obtain their views about issues relating to the PMS. Over 270 responses were received, and the results are discussed in more detail in Chapter 22. The Committee accepts that these results have no scientific validity, but believes that the findings are interesting nonetheless. One question asked of inmates by the Committee was whether they had any health problems. 151 inmates (56% of the sample) answered that they did.

Characteristics of the gaol population also influence the health needs of the group. For example, Aboriginal Australians in the general population often have poor levels of health, and they are over-represented in the prison population.\(^6\)

The existence of heavy industry, craft, industrial machinery and other tools in a number of gaols provides the potential for serious accidents to occur. The Committee was informed that the Occupational Health and Safety requirement that first aid kits be provided was not complied with. DOCS staff informed the Committee that security considerations preclude the availability of the necessary equipment and medicines.

**RECOMMENDATION**

2. That a survey of the health status of inmates of NSW custodial institutions be commissioned by the Minister.

3. That occupational health and safety strategies consistent with the constraints of security requirements be developed in NSW gaols.

**FOOTNOTES**


(2) "Health Status of the New York Prison Population" Medical Care (1977) 15, 205-216).

(3) Department of Corrective Services, Profiling Study, Unpublished Research.


CHAPTER 5

5.0 LOCATIONS SERVED BY THE PMS

5.1 Gaols

A full list of institutions served, their security classifications and their populations appears at Appendix D. In summary, full-time prisoners may be accommodated at any one of 25 different institutions in NSW, and there are a further nine Periodic Detention Centres. These institutions range from the small Detention Centre at Broken Hill with 20 inmates to Parramatta Gaol in Sydney's west with a population of almost 500. A new gaol has recently been completed at Lithgow, and another gaol is planned for Silverwater. A new private gaol is under construction at Junee.

Most inmates are located in the Sydney metropolitan area. The Long Bay Complex at Malabar has a population of approximately 1,500 in its 6 gaols, and a further 1,600 or so prisoners are located in the 6 western metropolitan gaols. The remaining prisoners (approximately 2,300) are located in 14 country institutions.

As with most services, there are some problems common to both country and city gaols. However, country institutions also face their own specific difficulties affecting the provision of medical services. Oberon Afforestation Camp, for example, is sometimes completely isolated because of adverse weather conditions, and because the road to the camp is long and in poor condition.

City, metropolitan and country areas all have a mixture of minimum, medium and maximum security institutions. Some gaols (e.g. Bathurst) have a range of classifications within one complex, which creates attendant problems of access and security in delivering medical services.

Apart from the new facilities, most other gaols in NSW were constructed in the 19th Century, based on models from Victorian England.

5.2 Periodic Detention Centres

There are nine Periodic Detention Centres (PDCs) operated by the Department of Corrective Services, with a new one being planned. These PDCs are listed in Appendix D.

As the name suggests, offenders generally are detained in PDCs for limited periods of time, such as over weekends. At that time few PMS staff are on duty.

The PMS is responsible for providing services to these centres, but in fact very little medical care is available to inmates other than in emergencies.
5.3 Physical design of gaols

The design of most NSW gaols has implications for medical services:

- the buildings are both oppressive and depressing, contributing towards a negative environment for both inmates and staff.

- they were built at a time when the number of prisoners was vastly different from that of today. Although possibly adequate at that time, today there is acute overcrowding. This point was made by Mr Justice Nagle in 1976 and overcrowding has increased steadily since then.

- they were not built with health care in mind. Most of them were established well before any Prison Medical Service existed. Consequently, physical facilities for providing health care are severely limited. Although the new hospital at Long Bay is modern and purpose built, in many gaols, medical services are provided from totally inadequate accommodation. Facilities for psychiatrally disturbed women prisoners were described in one Superintendent Survey as "disgraceful" and "woefully inadequate".
6.0 ADMINISTRATIVE RESPONSIBILITY FOR THE PMS

Since 1968, the PMS has been administered by the Department of Health. Prior to that, responsibility lay with the Department of Prisons, the precursor to the current Department of Corrective Services.

The functions and objectives of the PMS and DOCS differ significantly. The PMS, as part of the Department of Health, is concerned to ensure the delivery of appropriate health services and to improve the health status of the prison population. In contrast, the DOCS has a primarily custodial orientation.

Staff of both the Department of Health and the Department of Corrective Services commented that the relationship between the two Departments was generally good. It was evident to the Committee that staff of the Department of Health held many staff of DOCS in high regard, and vice versa. Notwithstanding this, some conflict between the opposing objectives referred to above is arguably inevitable where health care is provided in a prison environment. This conflict is referred to by commentators on Prison Medical Services in many jurisdictions and is acknowledged by many nurses and Superintendents in NSW gaols.

It is almost inevitable that there will be differences in philosophy between staff of the PMS and the DOCS. Almost all nurses and Superintendents, when asked by the Committee whether they had experienced clashes between health and correctional objectives, answered affirmatively.

"Because of the contradictory nature of the nurse's duties and that of a prison officer, Corrective Services often see us as "crim lovers" but we're not here to judge or punish inmates" (Nurse Survey).

"At .... gaol, the relationship between medical and custodial staff is strained. There has always been an us and them syndrome. There is little cooperation between the staff" (Superintendent Survey).

As one senior executive in the Department of Corrective Services said to the Committee "to the PMS, prisoners are patients; to us they are persons deprived of their liberty". Issues such as provision of condoms, and the management of medication by prisoners are generally seen differently by health and custodial staff. Nursing staff, in particular, informed the Committee of ethical dilemmas faced in the course of their work. Examples mentioned were:

- where they had witnessed assaults on prisoners by police or custodial officers, but concerns about personal reprisals prevented them reporting the incidents
where they had felt pressure to administer health care or medication in a way contrary to their own professional standards

where prison officers had been reluctant to transport prisoners on medical grounds.

"When I first started work at the clinic, (officers) were somewhat negative and resented the way I treated the inmates... they wanted me to mould myself on the custodial model and I saw my role as being quite apart from them" (Nurse Survey).

In Queensland, Western Australia and the Northern Territory, the Corrective Services Departments have responsibility for providing medical services in prisons. In Tasmania the Department of Community Services has responsibility. In Victoria, responsibility for provision of health services to prisoners lies with the Health Department, but a Corrections Health Board, composed of senior staff from the Office of Corrections and the Department of Health, reports to both Ministers. In South Australia, as well as in NSW, the Department of Health has responsibility. In England, the PMS is part of the Prisons Department which is in turn part of the Home Office.

Senior Executives of the DOCS put the strong view to the Committee that administration of the PMS should return to that Department, so that Superintendents could have direct responsibility for all aspects of prison life. It was submitted that this would remove problems which arise from the PMS not being directly under the "control" of DOCS. In contrast, staff of the Department of Health believed strongly that responsibility should remain with that Department.

It should be noted that the UN Standard Minimum Rules for the Treatment of Prisoners state:

"medical services should be organised in close relation to the general health administration of the community or nation".

The issue of whether DOCS should again have responsibility for the PMS has been addressed at least twice in recent years. The interim report of the Royal Commission into Aboriginal Deaths in Custody stated:

"it is absolutely essential that the PMS be seen to be, and in fact is, completely independent of the Department of Corrective Services."(2)

At the request of the Minister for Health, the issue was then discussed again by a group of officers from the Departments of Health and Corrective Services. The report was issued in October 1988. The Working Group looked at professional, ethical, legislative and industrial relations matters. Significant professional matters included the need for the PMS to be competitive with other health institutions, the Department
of Health's advantages in such matters as monitoring of health care standards, providing infrastructure support, and in professional relationships with the health care system generally. It also referred to major ethical considerations relating to the privacy of medical records. The group concluded that on balance the transfer was not advisable. It recommended that the Minister for Health's concern for the closer monitoring of the PMS could be addressed by the formal establishment under legislation of a joint management board. The Committee agrees with the Working Party that these considerations are highly relevant.

It is obviously desirable and necessary for the PMS to adopt and maintain high professional standards and to attract and maintain high quality staff. Problems of recruitment in correctional health are well known. The Department of Health has a number of advantages over the DOCS in this regard. In particular, it offers:

- an ability to set and monitor professional and ethical standards
- close contact and liaison with other health professionals
- an ability to provide back up and support to health professionals through existing infrastructure
- an ability to negotiate and obtain clinical specialist service providers
- experience in determining health staffing levels.

The Committee is also aware that ethical dilemmas may be raised in correctional health, and that PMS staff feel that DOCS staff may bring pressure to bear for ethical standards to be varied to suit the needs of DOCS. The Committee's view is that this conflict should be resolved in favour of health. This conflict is less likely to arise if administrative responsibility is with the Department of Health.

It should be noted that even if a transfer of responsibility to DOCS was carried out, the Department of Health would retain some legislative responsibility for the PMS, in relation to forensic patients and the prison hospital.

Perhaps most importantly, the location of a prison medical service within the existing health structure strengthens the perception (and reality) of an independent medical service which has health care as its main priority. That perception is most likely to be furthered if responsibility remains with the Department of Health, and it is more likely to be lost if it is placed under the administration of the Department of Corrective Services. With the exception of some DOCS staff, this view was shared by almost everyone contacted by the Committee.

The Committee recognises that there are legitimate complaints from DOCS about certain aspects of the operation of the PMS. As the Working Party concluded in 1988, this should be addressed through the development of an appropriate and efficient management structure. This is discussed in the next chapter.
RECOMMENDATION

4. That administrative responsibility for the PMS remain with the Department of Health.

FOOTNOTES

(1) R. Smith, Prison Health Care, British Medical Association, 1984, p.94.

(2) Royal Commission Into Aboriginal Deaths in Custody, Interim Report, p.54.
CHAPTER 7

7.0 ORGANISATIONAL STRUCTURE OF PMS

7.1 Current Structure of PMS

The PMS is established as a fifth schedule hospital under the Public Hospitals Act, and current structures provide that it is responsible and accountable to the Director-General of the Department of Health. On page 40 is an organisational chart reflecting the current structure of the PMS. As this chart reflects, the Director of the PMS is the most senior person in the organisation, and all positions below that are responsible to him. These positions include the Director of Nursing (responsible for nursing services), the Deputy Director of the PMS (responsible for staff medical officers, visiting General Practitioners and specialists and paramedical services), and the Director-Administrative Services (responsible for financial and personnel matters, and domestic and catering issues). The Director of the PMS reports through the Deputy Chief Health Officer to the Chief Health Officer of the Department of Health.

The PMS provides services to inmates, who are the responsibility of DOCS, but there are no formal reporting mechanisms between the two organisations. There are however informal links such as regular meetings of a liaison committee comprised of representatives of both DOCS and the Prison Medical Service.

On page 41 is a chart which sets out the areas of functional responsibility which the Committee believes to be of primary importance to the PMS. As detailed below, the Committee believes that these areas should be headed by appropriately qualified experts, with day to day management devolved to individual gaols. This would address the problems of organisation and accountability referred to below, and would lead to a significant flattening of the current bureaucratic structure, which the Committee believes is desirable.

7.2 Importance of accountability

The desirability of an effective management structure which facilitates the accountability of the PMS to the wider community it serves cannot be overemphasised. The establishment of health management boards responsible for controlling and delivering health services to prescribed populations is one way in which accountability has been increased in the health care system.

This move is consistent with legislative and administrative reforms across the public sector generally, all of which aim to encourage responsibility and accountability in public administration.

In the course of this review, the Committee was informed of many problems which militate against the PMS being efficient, effective and accountable. The Committee now believes that many of the problems reported about the operation of the PMS are directly traceable to organisational and management problems.
It is recognised that there are many factors which distinguish the PMS from other health facilities. However, the Committee believes that consistent with the principle of equality of medical care between prisoners and the general community, developments in other health structures should be reflected in the PMS unless there are compelling reasons otherwise.

7.3 Need for PMS Board of Management

At the present time there is no Board to whom the PMS is accountable. This is in contrast to other health services in New South Wales. There has in fact been no formal Board in existence since the Prison Health Management Board, established by the Ministers for Health and Corrective Services in 1988, ceased operation in 1990. Consequently, there is no single management body with responsibility for providing oversight of administration or development of policy in the PMS. The Committee is convinced of the importance of establishing an effective Board. Considerable support for such a move has been expressed to the Committee by staff within the PMS and by representatives of other organisations.

In the Committee’s view the Board should have policy, planning and operational functions, including:

- determining objectives and priorities for the PMS
- establishing policies to obtain these objectives
- monitoring the achievement of these objectives
- assessing the appropriateness of proposals for change, in the light of determined objectives
- managing services within the budget
- assessing the resource implications of proposals for change.

An option considered by the Committee was to bring the PMS into the established area health service structure, for example, by bringing it within the purview of an existing Area Health Board, such as the Eastern Sydney Area Health Board. Other fifth schedule hospitals have been transferred in this manner.

The Committee’s view was however that there are two major problems with this approach. Firstly, not all of the PMS is located in one geographical area, as gaols are widely distributed across the state. Area Health Services, by definition, have a strong focus on a single geographic area.

Secondly, there is a strong possibility that services to prisons would be afforded a low priority in comparison with non custodial services.

The Committee strongly believes that a Board is vital to the future development and operation of the PMS. Such a move is consistent with government policies of decentralisation of administrative functions.

Accordingly the Committee recommends the establishment of an independent Prison Medical Service Board (see below).
7.4 Membership of Board

In the Committee’s view, the Board must be independent, with representation of essential interests (such as the Departments of Health and Corrective Services) and also of relevant outside bodies which can provide valuable scrutiny of the organisation and input into the decision-making process. This is consistent with trends in the structures of Boards of other health facilities. The Chairperson for the Board should be an eminent person selected from the community, and not from any government department.

It is also important that there is a capacity for an elected staff representative at Board level. This allows input to management from staff, who have valuable day-to-day experience in operational aspects of the PMS, and facilitates effective communication between staff and management. The Committee is aware that problems have arisen from the lack of consultation with staff, and there is evidence of a poorly articulated and inconsistent consultative process at the Executive level. Presence of staff at Board meetings ensures that major policy decisions are communicated in an unambiguous way, overcoming current problems of lack of information flow and inconsistency in decision making.

The Committee therefore recommends that membership of the Board include individuals with a range of relevant experience and expertise (see below).

7.5 Sub-Committees

The establishment of a Board would provide the flexibility for sub-committees to be formed and deal with specific issues. An example of an appropriate role for a sub-committee is in dealing with conflict resolution in the PMS. At present there is no mechanism for conflict resolution if disputes occur between senior officers of the PMS, or between the Director of the PMS and any other individual. Yet the Committee is aware that there are continuing irritations and disputes in the PMS which have proven to be quite destructive of relationships and morale. Attempts to resolve these disputes have ultimately involved a number of outside people who have no direct responsibility in the matter.

The lack of provision for appropriate appeal against decisions leads people working within the system to feel powerless and subject to capricious management decisions. A Board representing a variety of interests would provide a much better mechanism for resolution of disputes arising from management decisions. A central, representative sub-committee, with direct responsibility to the Board could assume the role of arbiter in in-house professional and industrial disputes.

7.6 Role of Board in Planning and Monitoring

The Committee views the development of a corporate or strategic plan as essential to a changing and dynamic service such as the PMS. Such plans can create a sense of purpose and direction for the Service’s staff as well as provide a base-line from which
functions can be expanded or reviewed. The Committee believes that it is important to develop a corporate plan for the PMS which takes into account both initiatives in the local health care field and relevant United Nations principles. Organisational objectives which are specific and quantifiable should be developed as a result of such planning. This will provide guidance to incoming members and staff, and allow evaluation of Board (and staff) performance. This is most important in terms of public accountability.

The Committee was unable to identify any clear statement of aims and objectives for the PMS nor any corporate or strategic plan for the future, although the Nursing Orientation Manual sets out service objectives. However, the Director of the PMS informed the Committee that in general, the PMS tries to adhere to international covenants and standards regarding the treatment of prisoners.

The Committee's view is that decisions about the adoption of new areas of work for the PMS have been made without sufficient planning or consultation. For example HIV testing was commenced and additional responsibility was assumed by the PMS for the methadone program, without due consideration of the implications for an already "stretched" service.

The Board's role in developing policy would allow for major issues to be discussed in detail, analysed and commented on in a formal setting.

The Board would be regularly provided with evidence of proposed local plans, so that it could assess the appropriateness of such plans in the light of the previously formulated corporate objectives. It would also request evidence of mechanisms to put these plans into effect, and statements as to how outcomes are to be measured.

7.7 Cost of New Structure

The Committee's view is that a Board could be established at little additional cost. It is anticipated that only 3 members of the Board would require payment for their participation, and that this would cost less than $15,000 per year. Such expenditure would be offset by increased organisational and structural efficiency. A number of support staff are currently employed by the PMS and work generated by the Board could well be absorbed within the existing resources.

7.8 Problems of Current Organisation Structure

A number of specific problems arising from the current organisation of the PMS are detailed below. It was the Committee's firm view that the problems documented are symptomatic of structural problems rather than personal disputes.

As detailed in Chapter 1 of this report, section 9(1) of the Prisons Act provides for the appointment of one or more "medical officers" for each prison. Such appointments must be made upon the recommendation of the Minister for Health, with the concurrence of the Minister for Corrective Services. These medical officers are subject to the direction and control of the Director, Prison Medical Service.
It has been submitted to the Committee that the current arrangements reflect an "impractical approach" and that it is physically impossible for the Director to exercise responsibility with respect to the numerous and geographically disparate prisons within the State.

In the current PMS structure, all responsibility ultimately rests with the Director, reflecting the statutory duties of this position. Given the recent growth in the PMS, the additional functions assumed in recent years, and the size and complexity of the organisation, it is impractical for any one individual to have personal involvement in all decisions, or to take on responsibility for all operational aspects. As with any large organisation, there is a need for effective delegation.

The current PMS organisational chart indicates that there is some delegation of responsibility from the Director of the PMS to the Deputy Director, to the Director of Nursing, and to the manager. Any delegation of responsibility must however be accompanied by delegated authority.

It is the Committee's view that in practice such delegation in the PMS is impermanent and always subject to cancellation. It is frequently not accompanied by authority to make decisions and to act. For example, despite apparent delegation of responsibility to the Director of Nursing, decisions made on nursing issues at that level may be countermanded by the Director without consultation. This has caused considerable anger, frustration and uncertainty, particularly where the Director of Nursing feels he is competent to make the decisions. It has also caused considerable uncertainty about the extent to which decisions will be adhered to. Interviews conducted with nursing staff by Ms Closs similarly showed the extent to which nursing staff perceived inappropriate intervention by the Director of the PMS across professional boundaries.

Many nurses stated that they are uncomfortable about what they perceive to be a direct reporting role to the Director of the PMS (a medical officer), rather than through the Director of Nursing. They also complained that their authority is undermined and that their relationships with patients are affected by this practice.

The Committee believes that there is a need to clarify roles and to designate responsibility and authority at appropriate levels throughout the PMS.

Undoubtedly consultation and free exchange of information is extremely useful and the Committee does not doubt the benefits of drawing on the expertise of others. However, this does not affect the need to devolve power to make decisions within an area of responsibility once such consultation has taken place. Only if problems are unable to be satisfactorily resolved at the delegated level, should there arise a need for intervention or involvement of superiors. This is in contrast to staff perceptions that the Director effectively "vets" all decisions. Delegation therefore needs to be clear and effective, and authority as well as responsibility must be clearly devolved.

In the management of general hospitals it is now unusual for a single individual to occupy a position with combined clinical, executive and policy formation and
administrative duties. These activities are now more normally separated and distinct functions located at different levels and in different roles. In contrast, the Director of the PMS is the chief executive for the organisation, and is also the nominated medical officer under the Prisons Act, and the authorised prescriber for the methadone program. Instances have been reported to the Committee of the Director allegedly assuming a role in clinical decisions, despite the lack of direct clinical responsibility for individual patient care.

Where one individual is vested with responsibility and has power to make decisions across a number of different areas, there is the potential for a conflict of interest between the roles.

The PMS currently provides a range of services, including medical, psychiatric and dental care. Responsibility for these services, although ultimately resting with the Director is shared to some extent by other individuals through a series of other mechanisms: for example the Chief Dental Officer of the Department of Health has a nominal responsibility for dental care, but has little involvement with the running of the PMS; and until recently there was a part-time Acting Director of Psychiatric Services.

In the Committee's view, there is an urgent need to separate the various management and clinical functions undertaken by the PMS and to allocate responsibility for these areas at an appropriate level. Each area should be under the direction of a suitably qualified person who should take on a clinical role where appropriate. This will assist in both increasing accountability and clarifying roles.

The Committee believes it is also necessary to establish a position of Chief Executive Officer. Responsibility of the CEO position in the PMS should include implementation of Board policy, administration of the PMS and liaison with and provision of reports to the Board. As this position is primarily a management one, medical qualifications would not be a prerequisite for the position. This will assist in overcoming the problems referred to above.

The Committee therefore recommends that the functions of the PMS be separated and responsibility allocated to separate individuals, and that a position of Chief Executive Officer be established (see below).

Unlike general hospitals, the PMS operates within physical confines controlled by another Department, and is unavoidably affected by the rules, regulations and cultural mores of that Department. Structured, organisational support for PMS staff from all agencies and staff within the health network is therefore important at all levels. This will strengthen the identity of the Prison Medical Service as an organisation with a health, rather than custodial orientation.

The Committee's information has not revealed such support to be substantial. In fact there is sometimes ambiguity about the "affiliation" of the PMS. This applies at a number of levels. Some professional staff believe that PMS staff are frequently not sufficiently independent of custodial influences; some prisoners see the PMS as being
part of the DOCS; and even at a formal bureaucratic level, there is a lack of
identification between the PMS and the Department of Health. For example, statistics
relevant to the PMS appear in annual reports of the Department of Corrective
Services, rather than the Department of Health.

This ambivalence or lack of clarity about the affiliation of the PMS has a number of
implications. Firstly, staff feel isolated from public health facilities, support and
organisational structures. Secondly, they are potentially more subject to the influence
of custodial imperatives. Thirdly, the potential availability of public health facilities
to prisoners is decreased. For example, the Committee was informed of instances of
significant antipathy being demonstrated towards prisoners by staff of public hospitals.
On a purely economic level, the lack of knowledge of, and familiarity with, local
health services often results in increased demands on the centralised services at Long
Bay, and, therefore on escorts and transportation. The Committee believes that if
there were stronger links between the PMS and other parts of the public health system,
such problems would occur less often and where they did occur, would be more easily
resolved. Links could be developed through such measures as membership of Boards
and Management Committees of local services by PMS Board members or PMS staff;
development of combined seminars and training programs, and, where appropriate,
seconment of staff. In the Committee’s view, links with tertiary institutions would
also be most beneficial to the PMS, providing the opportunity for research to be
conducted and the profile of the PMS to be increased.

A number of staff have individually developed relationships with local and area
hospitals, and have commented on how productive this has been. They have referred
to benefits such as invitations to seminars, gaining familiarity with the local services
and providing understanding of the role and function of the PMS to staff of those
other organisations. Yet there is little evidence of this process being undertaken on
a formal level. The promotion of stronger ties between the PMS and other aspects of
the public system could benefit both areas.

The Committee therefore recommends that the Board urgently consider how best
links between PMS and other health care services and tertiary institutions could
be established (see below).

Decision-making in the PMS is, on the whole, heavily centralised with administration
and decision-making based around Long Bay. This applies to major policy issues but
also to matters such as purchasing of stores, and the day to day administration of
prison clinics.

In the Committee’s view, responsibility should be devolved to a local level, as far as
possible, to allow services to be provided closer to people, and to increase
accountability.

The PMS administration attempts to provide support to country staff, and these
attempts are acknowledged by the Committee. The geographic locations of prisons
however constrain the effectiveness of such support. For example, one nurse in a
country gaol complained that she received no support from executive staff following
a work-related injury. Particularly in situations of vulnerability, feelings of alienation can easily arise. A structure which devolved responsibility to a regional director would allow contact to be maintained and developed. The current centralised organisation causes concern particularly to staff in country areas, and exacerbates feelings of isolation.

"In a remote clinic situation immediate back-up from Long Bay is not always available" (Nurse Survey).

Ms Closs described the current situation in relation to rosters:

"Preparing and maintaining an adequate roster system appears to consume an inordinate amount of time both by the NUMs of each area, their supervisors, the Assistant Director of Nursing Personnel and the Deputy Director of Nursing."

In practical terms, problems can often be more easily resolved at a local level - for example rostering functions can be more easily monitored and adjusted locally. It is the Committee's view that responsibility should therefore be devolved to service areas with appropriate management support. As stated above, however with such delegation of responsibility must be appropriate delegation of authority.

Nursing Unit Managers complain that they have only a limited management function with much of their time being occupied with clerical work or other nursing functions. Notwithstanding this, they perceive that they are left to carry the responsibility if something goes wrong.

The DOCS has an expressed policy of working towards "unit management". The development of "gaol health teams" is a move which is consistent with the Unit Management approach. It appears logical to the Committee that Nursing Unit Management should be able to develop in a similar manner. This will also increase accountability at the local level.

The Committee believes that decentralisation of decision-making and priority setting should be encouraged, with the lead for this move coming from both the Board and the Executive. A formal policy outlining the principles of devolution of authority and responsibility within the organisation should be developed by the Board on its appointment.

The Committee therefore recommends that responsibility and authority be devolved as far as possible to the site of service provision (see below).

The Committee understands that the organisation and structure discussed above could be achieved either under existing legislation or through the enactment of a separate Prison Medical Service Act.
7.9 Options for the delivery of health services to prisons.

It is important that the proposed Board is not constrained by the existing mechanisms of service delivery. Those service areas identified in other parts of this report which required major upgrading must be addressed, for example, psychiatric and dental services.

Innovation in the delivery of efficient, cost effective services should be encouraged. Models considered by the Committee included a funder/provider split whereby the Board is the funder and via contracts to providers ensures that the required services are provided to agreed standards. This is a model being explored for the medical services to privatised prisons.

In whatever model is adopted by the Board it is however critical that appropriately qualified experts have the authority and responsibility for specific services.

RECOMMENDATIONS

5. That as a matter of priority a Board of Management for the Prison Medical Service be appointed by the Minister for Health Services Management.

6. That membership of the Board be as follows:-

- Chairperson
- Department of Corrective Services nominee (1)
- Department of Health nominee (1)
- Community nominees (2)
- Representative of Prison Medical Service Staff (1) (elected position)
- Chief Executive Officer of the Prison Medical Service

7. That consideration be given to drawing community representatives from groups such as:-

- Community Health Centres
- Groups providing health services to specific groups e.g. Drug and Alcohol, AIDS Services
- Universities
- Aboriginal organisations
- Women's groups
- Legal services
- Prisoners' organisations

Selection of the Board should ensure that there is management expertise available in its membership.

8. That the Board have policy, planning and operational functions including
determining objectives and priorities for the PMS
- establishing policies to obtain these objectives
- monitoring the achievement of these objectives
- assessing the appropriateness of proposals for change, in the light of
determined objectives
- managing services within the budget
- assessing the resource implications of proposals for change.

9. That the Board report annually to the Minister.

10. That the Board develop:

(i) a strategic plan for the PMS, with a statement of aims and
objectives which are consistent with UN standards and principles,
and local health care initiatives; and
(ii) a formal policy outlining the principles of devolution of authority
and responsibility within the organisation.

11. That the Board consider mechanisms for establishing formal and informal
links with tertiary institutions and other medical and health-related
agencies and personnel, such as community health centres and local
general practitioners.

12. That the position of Chief Executive Officer of the PMS be established.
This officer need not be a medical practitioner, but should have
demonstrated administrative experience and management expertise.

Responsibilities of the Chief Executive Officer should include:—
- implementation of Board policy
- administration of the PMS
- liaison with and provision of reports to the Board.

13. That in the organisational structure, appropriately qualified experts are
identified to have the authority and responsibility for specific services
including primary care, nursing, psychiatric and dental services.

14. That as far as possible, responsibility and authority for the administration
of PMS services be devolved to local unit level, with regional support
provided to local managers.
CURRENT STRUCTURE FOR ORGANISATION OF PRISON MEDICAL SERVICE

MINISTER

DIRECTOR-GENERAL DEPARTMENT OF HEALTH

CHIEF HEALTH OFFICER AND EXECUTIVE DIRECTOR, DIVISION OF PUBLIC HEALTH

DEPUTY CHIEF HEALTH OFFICER

DIRECTOR, PMS

DEPT. OF CORRECTIVE SERVICES

DIRECTOR OF NURSING

DEPUTY DIRECTOR OF NURSING

ASSISTANT DIRECTOR OF NURSING

N.U.Ms

NURSES

DEPUTY DIRECTOR

STAFF MEDICAL OFFICERS

VISITING G.Ps & SPECIALISTS

PARAMEDICAL SERVICES

MANAGER

FINANCIAL

SALARIES

PERSONNEL

CATERING

DOMESTIC

MEDICAL RECORDS

Abbreviations:
NUM Nursing Unit Manager
GPs General Practitioners
PMS Prison Medical Service
KEY AREAS OF FUNCTIONAL RESPONSIBILITY IN THE PRISON MEDICAL SERVICE

Minister for Health

PMS Board

Department of Corrective Services

Chief Executive Officer

Finance/Administration Support

Nursing Services

Primary Care Services (GPs and Specialists)

Hospital Services

Psychiatric Services

Dental Services

Gaol Health Teams

DOCS Staff with Health related functions
CHAPTER 8

8.0 PMS BUDGET

8.1 Budget Allocation

The following table sets out the budget allocation and actual expenditure for the PMS since 1984.

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget ($000)</th>
<th>Actual ($000)</th>
<th>Variance ($000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990/91</td>
<td>10,742</td>
<td>10,213</td>
<td>533 (deficit)</td>
</tr>
<tr>
<td>1989/90</td>
<td>9,680</td>
<td>8,780</td>
<td>270 (favourable)</td>
</tr>
<tr>
<td>1988/89</td>
<td>9,050</td>
<td>7,103</td>
<td>1,350 (favourable)</td>
</tr>
<tr>
<td>1987/88</td>
<td>8,453</td>
<td>5,549</td>
<td>1,939 (favourable)</td>
</tr>
<tr>
<td>1986/87</td>
<td>7,488</td>
<td>4,123</td>
<td>107 (deficit)</td>
</tr>
<tr>
<td>1985/86</td>
<td>4,014</td>
<td>3,520</td>
<td>1 (favourable)</td>
</tr>
</tbody>
</table>

Of approximately $10.7 million allocated to the PMS for 1990/91, funds are spent on a number of items, including:

- staff salaries and on-costs (e.g. superannuation)
- medical services (including screening)
- the prison hospital
- dental care
- specific programs (e.g. AIDS/Methadone)

Although the PMS has assumed some responsibility for providing medical services to juvenile justice institutions, as at May 1991 no funds had been transferred to the PMS for this purpose. The Department of FACS had been billed by the PMS for some costs of establishing and administering the service. Nursing staff in juvenile justice institutions were being paid directly by FACS.

8.2 Difficulties in Obtaining Information on PMS Budget and Activity

It should be noted at this point that the Committee had great difficulty in establishing exactly how money allocated to the PMS had in fact been spent. This was a problem shared by others responsible for financial monitoring of the PMS. This was due to the fact that:

- existing accounting practices allow for considerable transfer of funds between nominated areas without proper recording of the details; and
there is limited statistical information available in relation to such matters as activity levels of staff and service utilisation rates.

8.3 Calculating Appropriate Funding

The Committee notes that despite a number of reported difficulties by the DOH in obtaining financial information from the PMS, the last audit of the Service was conducted in 1989. The Committee believes that a systems based audit would be most useful and instructive.

The Committee’s strong view is that funding for the PMS should be at such a level that the medical, nursing and dental services provided by the PMS to the full-time prison population are equivalent to those available to the general community. It is the Committee’s view that health screening and risk assessment for all prisoners entering the gaol system should be routinely provided and that prisoners at Periodic Detention Centres should receive a reasonable level of health services.

The number of variables involved and the paucity of available data makes exact determination of the financial needs to provide such a service difficult.

The present yearly fund allocation is made on an historical basis, with the previous years funding being adjusted for C.P.I. and enhanced if acceptable arguments are put and funds are available. In the Committee’s view, this has resulted in an inadequate amount of funding being made available, and services that are not adjusted to the level of need.

In the past, limited adjustments have been made to take account of the large increase in the prison population, which has been approximately 50% in the last 2 years. (See Chapter 3). The Committee believes it is important that funding decisions take into account the size of the population served, and allow for continual adjustments related to that population.

In 1987/88 $23.4 billion was spent on health care in Australia. This amounts to $1,415 per citizen. This figure includes State and Commonwealth funding (Medicare). If health infrastructure and other services (e.g. ambulance services) are deducted, this amount would be minimally smaller. However, even if health funding has only risen in relation to C.P.I., the adjusted 1990/91 figure would be $1,782 per citizen.

In contrast the adjusted per capita expenditure on health care of prisoners by the PMS is shown on the following table. Figures are based on the annual average number of full-time prisoners.
<table>
<thead>
<tr>
<th>Year</th>
<th>Actual Budget</th>
<th>Population</th>
<th>Amount per prisoner</th>
<th>Adjusted figure (June 1990)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-91</td>
<td>10,742</td>
<td>6,300</td>
<td>$1,705</td>
<td>$1,839</td>
</tr>
<tr>
<td>89-90</td>
<td>9,680</td>
<td>5,686</td>
<td>$1,702</td>
<td>$2,170</td>
</tr>
<tr>
<td>88-89</td>
<td>9,050</td>
<td>4,867</td>
<td>$1,859</td>
<td>$2,340</td>
</tr>
<tr>
<td>87-88</td>
<td>8,453</td>
<td>4,524</td>
<td>$1,868</td>
<td>$2,386</td>
</tr>
<tr>
<td>86-87</td>
<td>7,488</td>
<td>4,294</td>
<td>$1,743</td>
<td></td>
</tr>
</tbody>
</table>

It should be noted that periodic detainees have not been considered as part of this calculation nor has the annual throughput of prisoners.

The number of prisoners in periodic detention is increasing. In June 1991 there were 1,250 such prisoners. In 1991, prisoners in periodic detention comprise 21.3% of the total population, compared to 9.6% in 1988.

It is estimated that approximately 20,000 prisoners pass through the prison system in any one year. In the Committee’s view, these prisoners need at the minimum, some level of initial health screening and risk assessment, and some will require further services as a result.

The table indicates that the amount allocated per prisoner in real terms is declining. At the same time functions performed have increased. Unless there are major allocations of funds to the PMS for the next few years, the increase in the rate of the prison population is likely to lead to further compromise in service provision.

It appears to the Committee that a prima facie case exists for an upward adjustment of funds to be made to the PMS to take into account the increase in full-time prisoner numbers, services for prisoners in Periodic Detention and an adequate health screening and reception process.

Other sections of this report address the ways in which the Prison Medical Service differs from other facilities (Chapter 1). Some of these factors increase the costs of providing health care to its population in comparison with the general population, for example:

- low socio-economic status
- high morbidity
- high proportion on the methadone program
- the high incidence of trauma suffered prior to and during incarceration
- the high proportion with histories of drug or alcohol addiction
- the fact that self medication is not possible, and there is very limited access to non-medical alternatives for inmates
- compulsory AIDS testing
- provision of all dental services and some optical services
- security requirements of DOCS
geographic dispersal of the PMS, which increases the need for supporting infrastructure.

In addition, prisoners have very limited access to any private health care services. In the general population about 23% of those in the lowest income group (from which most prisoners are drawn) have private health insurance.  The effect of this is that prisoners are denied access to a service available to their contemporaries in the general community, and the cost of providing services which might otherwise be borne by health funds must be borne by the PMS.

On the other hand, some factors decrease the cost of providing health care in prisons, e.g.,

- there is limited “high technology” medicine, or expensive capital equipment
- most of the population is young and male (a group which traditionally uses health services less frequently) with a correspondingly small proportion of women, and no young children
- some services are provided to prisoners by general public hospitals, at a cost met by Areas and Regions.

The average expenditure per full-time prisoner in NSW in 1990 was $1,821. Whilst this is higher than the national average expenditure per person on health care, the morbidity of the prison population, the special circumstances in which health care is provided and comparisons with Victoria indicate that the amount spent per prisoner in NSW is in fact low.

In Victoria, the total budget for the Prison Medical Service is $5.38 million comprised of:

- $3 million - primary care
- $1.8 million - psychiatric services
- $0.5 million - drug and alcohol services
- $0.08 communicable diseases services

There are 2,300 prisoners in Victoria, all of whom are in full-time custody. As drug and alcohol services are provided by DOCS in NSW, the comparable Victorian Budget is $4.88 million, or $2,121 per prisoner.

Comparisons with the Victorian prison medical service are probably more meaningful than any other comparison as they deal with the most similar populations. This comparison shows that NSW spends an average $300 full-time per prisoner less than Victoria. In addition, in June 1991 the NSW PMS was required to provide services to over 1,250 prisoners in Periodic Detention.

The Committee believes that a population based formula should be used as the basis for recurrent funding for the Prison Medical Service. For the 1991/92 financial year, a notional figure of $2,400 per full-time prisoner should be adopted, and then adjusted annually. This figure is similar to the amount allocated per prisoner, in
real terms, in previous years, is comparable to June 1991 adjusted per-capita funding for correctional health services in Victoria, and allows some weighting to take into account prisoners in periodic detention.

The Committee therefore recommends that funding for the PMS be increased to an amount of $14,097,000 and maintained in subsequent years.

Although this will involve some initial additional expenditure, there are long term benefits to this approach which will ultimately reduce costs. For example, an effective reception, assessment and screening process will assist in providing appropriate services and preventive health care, and therefore avoid more serious problems and costly interventions.

The Committee believes that there are some areas in which cost savings may be able to be made, for example, in the level of staffing of the prison hospital. The Committee was unable to fully investigate these matters, but believes that it is an important area for the Board to investigate, and that it may result in positive cost savings.

RECOMMENDATIONS

15. That the budget allocation be adjusted annually to take into account any increase in the prison population.

16. That for the 1991-92 financial year, based on a notional allocation per prisoner of $2,400, the funding for PMS be enhanced to a total of $14,097,000.

17. That the notional per-capita allocation be annually adjusted for inflation in line with Departmental practice.

18. That, as a matter of urgency, the Department of Health arrange for a financial audit of the Prison Medical Service, and ensure that appropriate monitoring and reporting systems are in place.
FOOTNOTES


(3) Information supplied to the Committee by Victorian Corrections Health Service Staff.
CHAPTER 9

9.0 NURSING SERVICES AND GAOL HEALTH TEAMS

9.1 Services Provided

All gaols in the State have some level of clinic services provided by PMS Nurses. The level of service varies enormously. At Brookfield Afforestation Camp, Mannus, there is one registered nurse available for four hours a day Monday to Friday, with no provision for on call or relief staff.

At the other end of the scale, the Assessment Prison in the Long Bay Correctional Centre is a maximum security gaol with a number of specialist units and a "medical hold" service (which means that inmates are unable to be moved until medical problems have been assessed and/or treated). The Nursing Establishment in this gaol is 6.5.

A key factor affecting the level of service is the number of nursing hours allocated to the facility which is in turn affected by other factors, including the population of the gaol. Services provided by clinics/nursing staff can be classified as follows.

(a) Primary Care Clinics

Inmates frequently present to clinics with injuries which have occurred as a result of accidents (including those resulting from industry or sport) or assaults.

Unless these injuries are sufficiently serious to warrant referral to a local hospital or doctor, or the use of the Ambulance service, nurses conduct examinations and provide immediate treatment.

Care of prisoners sustaining minor injuries and arrangements for transfer of prisoners in emergency situations are the responsibility of the nursing staff.

Nurses undertake work such as pathology specimen collection and arrange referrals for X-rays or consultation with outside agencies. They refer prisoners to doctors where appropriate and if requested.

(b) Emergency Medical Care

Nurses are frequently called upon to provide emergency services, for example, where suicide attempts have been made.

(c) Medication Dispensing

Medication is prescribed by medical practitioners and dispensed by nurses. Although this is not necessarily a very time consuming task, at any one time a large proportion of the gaol population is receiving medication. Documentation provided
to the Committee by the PMS Nursing Administration estimates that 65 of 214 inmates receive medication per day at Grafton; 100 of 484 at Parramatta; 50 of 114 at Brookfield Afforestation Camp; 200 out of 400 at the Reception Prison and 120 out of around 300 at Mulawa.

There is also a list of "Nurse Initiated Medication" which nurses are allowed to administer without reference to a medical practitioner. This list is generally restricted to medication available from pharmacies without prescription.

Prisoners must call at the clinic for all medication, including paracetamol (Panadol) or aspirin. Medication dispensing or "pill parades" can be held up to three or four times daily.

(d) Receptions/Screenings

The main centre for reception and classification of inmates in NSW is the Reception Prison. For 6 days of the week, 10-30 inmates per day are received at this centre. Not all prisoners are received through this gaol however. Except where inmates are received from other gaols, "medical screening" is conducted by a nurse, answering questions set out on a Reception Assessment Sheet. (Appendix G).

(e) Methadone Program

The Methadone program currently operates in most metropolitan gaols, but not in camps. The role of PMS nurses in relation to the program is generally limited to administering doses of methadone syrup, a function which is nonetheless quite time consuming.

(f) Counselling

Nurses have both a formal and informal counselling role. When the Prison Medical Service assumed responsibility for HIV screening, and administration of the Methadone program, counselling was to be provided by the PMS. There has subsequently been some controversy about the extent to which this is being provided, but some nurses undoubtedly play a role in providing counselling to HIV infected inmates and those on the methadone program.

In addition to this structured counselling many nurses are viewed by inmates as a sympathetic ear, someone from whom they can get a "friendly word" and who will show a genuine interest in their well-being. This is reflected in both nurses' and inmates' surveys.

"Nurses took the time to talk to me, which means a lot when you are in gaol, they were very caring" (Inmate Survey).
9.2 A Note on the Situation of Prison Nurses

For all professionals involved in the provision of health services, working in the prison medical service presents unique difficulties and challenges, and heavy demands are often made on their skills. This demand is felt acutely by nurses, who in practice carry a significant part of the workload. One nurse asked:

"(Have you) ever run a clinic, examined patients, administered drugs, dealt with sociopaths, drug addicts, hepatitis carriers etc. More over, have you ever told a prisoner - no you can't have it!" (Nurse Survey).

Many PMS nurses are physically isolated, either in their location within the gaol or at remote locations which are on occasions completely inaccessible e.g. Oberon Afforestation Camp is sometimes snowed in during winter.

Nurses are often the first port of call in medical emergencies. Although some prison officers have some knowledge of first aid, nurses are often required to make major decisions on medical matters. In contrast, in other nursing environments (e.g. hospitals) these decisions are frequently the responsibility of more senior staff. This responsibility can be a "double-edged sword". On one hand, it can be very stressful, but on the other hand it can be gratifying. One nurse said:

"Nurses assess a wide variety of medical cases on their own ... diagnosing and treatment of cases is often out of hours when MOs aren't available ..... satisfaction occurs in this area." (Nurse Survey)

"the inherent autonomy and extended role provides the potential for job satisfaction." (Nurse Survey)

On the other hand, there are difficulties arising from the nature of the patient group.

"the position of gaol clinic nurse should be given the greatest emphasis. Mature, well qualified and experienced people in this position are absolutely essential. Bearing in mind that prisoners (not all) can be most difficult and unreasonable patients - mannerless and rude - it is a very real challenge to the professionalism of the nurse to be able to manage this type of patient material. Failure to be able to handle this challenge very easily produces an embittered jaundiced participant on both sides." (Inmate Survey)

9.3 Problems with nursing services

Other sections of this report, particularly Chapter 7 (Organisational Structure of the PMS) and Chapter 17 (Staff Training and Development) deal with issues which are directly relevant to nursing services. They discuss problems raised directly by nursing
staff with the Committee, and problems raised in Ms Clos's report on nursing services. The Committee believes that recommendations made in those chapters will assist in overcoming many of these problems. Relevant recommendations from those chapters are reproduced below. The following discusses additional problems not expressly dealt with elsewhere in the report.

The current level of staffing for nurses is perceived to be inadequate by Superintendents, staff of DOCS, other professionals involved in the PMS and by nurses themselves. This point was also made very clearly by Ms Closs in her report on the organisation and administration of nursing services in the PMS

"In all of the facilities I visited, I did not observe any overstaffing of nurses. In most cases it would be fair to say that the nursing service carries an unfair load of the responsibilities attached to providing a health care service to the prison population in NSW".

The Committee agrees with this statement. Specialised nursing services are also perceived by some to be inadequate particularly in relation to methadone and the HIV testing program. This lack of staffing is felt acutely as the level of services required to be provided by the PMS increases.

PMS documentation supplied to the Committee states that nursing staff minimum levels are set bearing in mind a number of factors. These include "limited variables to current hospital usage" such as patient dependency and the competency and experience of staff. In addition events such as a prison officers' strike may mean that extra nursing staff are required. Attempts are made to avoid reduction in nursing services to patients, and it is acknowledged that vacancy factors mean the use of casual/part-time staff, as well as overtime when absolutely necessary to reach minimum staffing levels.

This documentation also states that because of budget deficits, staff rationalisation is reviewed monthly, and that variations in quality of care are reported verbally to the PMS executive at their meetings. Cuts are also apparently based on utilisation of beds, patient dependency, work value studies and patient management systems.

The Committee has seen no evidence that these criteria are used and questions the basis on which cuts are calculated. In fact it appears that budgetary priorities, rather than patient needs, determine staff levels.

Nursing staff state that they are not involved in decisions as to where cuts are made. The Committee believes that there should be some cost benefit analysis undertaken in consultation with nursing services before cuts are made to staff numbers.

The Committee is aware that there are difficulties in recruiting new nursing staff. This is not altogether surprising, given the nature of the gaol environment. Other gaol health services report similar difficulties, and the problem is not confined to the recruitment of nursing staff, but applies to gaol health care workers in a number of different professions. The Committee believes that a new organisational structure for
the PMS, and the extension of staff development programs will assist in providing a better working environment and in attracting new staff. Recommendations number 5 to 13 and 36 to 42 are particularly relevant to nursing services.

9.4 Gaol Health Teams

There are a number of people in the PMS who have put considerable effort into the establishment of Gaol Health Teams. The Director of Nursing has played a particularly instrumental role in this process.

A Gaol Health Team is described in PMS documentation as providing "a formally established and co-ordinated approach to managing and providing services to prisoners/clients by both the Prison Medical Service and the Department of Corrective Services". Objectives of Gaol Health Teams are:

- to co-ordinate the management of prisoners who have emotional or physical problems
- to improve communication amongst gaol personnel
- to attempt to keep prisoners within normal discipline as long as possible thus reducing the necessity for hospitalisation
- to provide more timely or preventative intervention contingent on feed back from staff such as Wing Officers, Unit Managers and other service staff
- to rationalise resources and reduce duplication of work
- to provide a case approach in managing the prisoner that will keep the Superintendent informed about the prisoner's progress or problems.

Members of the Gaol Health Team include the Superintendent, Career Medical Officer, Nursing Unit Manager, Domiciliary Nurse, Psychologist, Welfare Officer, Drug and Alcohol Counsellor and others. Individual members of the team are expected to identify prisoners requiring attention, and refer them to service providers. They should also report back to the team, meet formally with other team members and establish tangible strategies to deal with prisoners.

Implementation of Gaol Health Teams in prisons has been uneven. Although quite successfully established in some gaols, only a limited number of teams is currently operating. The Committee supports the establishment of Gaol Health Teams and the efforts of those who have contributed towards them. It believes that Gaol Health Teams reflect an important approach to gaol health care and are based on sound principles.

Recommendation numbers 5 to 13 and 36 to 42 are particularly relevant to nursing services.
CHAPTER 10

10.0 GENERAL PRACTITIONER CLINICS AND SPECIALIST SERVICES

Primary care is the mainstay of health, and prevention and early intervention are essential to decrease morbidity and ultimately health costs. The Committee believes that medical, nursing, dental and psychiatric services are most important for prisoners. Chiropractic and optometry services are also very important but the Committee was not able to fully investigate delivery of these services.

GP clinics, also known in prisons as "Doctors Parades" are conducted at all gaols except Berrima, where inmates in need of GP services consult a local practitioner. Career Medical Officers employed at the Long Bay Complex are allotted responsibility for each gaol in the complex. "On call" and emergency services are also provided by GPs.

Some specialist medical services (such as gynaecology, psychiatry and orthopaedics) are provided by Visiting Medical Officers (VMOs) who attend gaols on a sessional basis. At Long Bay, VMOs include an Ophthalmology Registrar, a Dermatology Registrar, a Physician and a Surgeon.

A number of other ancillary services are also provided. The Assessment Prison has an X-ray service for all the Metropolitan gaols, and it provides some physiotherapy services and has a specialist Outpatient Department. Pathology Services are obtained from agencies outside the gaol system.

Prisoners’ views about these services are varied, but in surveys sent to the Committee, many complained about long waiting times prior to seeing GPs and Specialists. Although there may be long waiting times for specialist services in the general community, most people are able to obtain access to GP services within a reasonable time.

"You may need to see a doctor today for a complaint you have today, but may not get the opportunity for some weeks" (Inmate Survey).

"It takes a while to see (the Doctor) ...... up to a month" (Inmate Survey).

"The doctor does not spend enough time with each person" (Inmate Survey).

Delays are partly due to the limited number of practitioners’ hours available, but they are often compounded by other factors, such as difficulties in obtaining escort services, which results in the cancellation of appointments and further delays. In addition, security requirements mean that the number of prisoners who can pass
through the system is very limited, and Medical Officers frequently have to wait for long periods of time before prisoners can be brought in to see them. As it is standard practice for nurses to be in attendance with doctors at clinics, clinics may be cancelled if nurses are not available.

The physical design of gaols, and the difficult work environment created by them means that the facilities and conditions in which these services are provided are stressful for health care staff and prisoners.

The Committee notes that the Royal Commission Into Aboriginal Deaths in Custody recommended that Correctional Institutions should provide 24 hour access to medical practitioners who are either available on the premises or on call (Recommendation 130). The Committee fully supports the requirement for 24 hour on call availability of medical practitioners, but does not believe there is a need for a full-time physical presence.

RECOMMENDATIONS

19. That the Board review the adequacy of GP and Specialist services to inmates.

20. That the Board seek the co-operation of DOCS to review procedures for referral of inmates to GP and specialist clinics with a view to ensuring that delay for such services is kept to an absolute minimum.
CHAPTER 11

11.0 PSYCHIATRIC SERVICES

Psychiatrists employed by the PMS provide both outpatient services and services to the psychiatric wards (Wards A, C and Ward D) at the Long Bay Prison Hospital. There is also a small "ward" set aside for psychiatrically disturbed women at Mulawa gaol, where psychiatrists visit in-patients. This "ward" is the Rose Scott Unit, which is greatly substandard. Where available, psychiatrically trained nurses assist with care of prisoners with psychiatric problems at the Long Bay Hospital, the Rose Scott Unit and in other gaols. A Clinical Nurse Consultant with the PMS has a background in psychiatric services. A Psychiatric Domiciliary Nurse was previously employed by the PMS but the position has since been cut.

There are twelve psychiatrists working in the Prison Medical Service, two of whom are in full-time employment with the PMS. There are ten sessional Visiting Medical Officers, and a trainee psychiatrist works with the PMS works for 7 hour per week. Until recently, Dr. Geo Gluckstern was the Acting Director of Psychiatric Services, but he has since retired from this position. As part of this role Dr. Gluckstern provided some administration for the services. The Committee is grateful to Dr. Gluckstern for supplying the following information.

As at October 1990 the total number of psychiatric hours per week available to the PMS was 110.0, which is equivalent to 3.14 full-time psychiatrists per week. Of this time, 68.75 hours were spent at the Long Bay Complex and the other 41.25 provided in the remaining prisons. This figure does not take into account absences for annual leave or court appearances. If these absences are subtracted, the amount of clinical time available is reduced. If one month's annual leave is taken by each psychiatrist, then the figure is reduced to just over 100 hours. As detailed below, PMS psychiatrists are also required to provide court reports and to attend court. When time is subtracted for this function there is significantly less time available.

The basic services provided by PMS psychiatrists are described by the former Acting Director, Dr. Gluckstern, as "overwhelmingly clinical". In support of this Dr. Gluckstern has advised the Committee that there were almost 3,000 out-patient consultations during the period from July 1989 to June 1990. 1,346 of these consultations were at Long Bay and a further 1,632 were in peripheral prisons. From the same period there were 675 admissions to the acute psychiatric ward of Long Bay Prison Hospital, and 178 admissions to the sub-acute psychiatric ward. Dr. Gluckstern states that in an acute psychiatric ward containing 28 beds and two "dry" cells (cells from which everything has been removed to prevent patients harming themselves), this means that the ward population turns over twice a month.

PMS psychiatrists also provide court reports, and reports to other bodies such as the Offenders Review Board, the Serious Offenders Review Board, the Mental Health Review Tribunal and inter-state Review/Parole Boards. A large number of such reports are provided each year. From these limited hours, the Acting Director of
Psychiatric Services must also provide administration of psychiatric services.

It should be noted that all psychologists in gaols are employed by the Department of Corrective Services and appear to function fairly independently of psychiatrists. The Committee understands that only two of the thirty four psychologists employed have clinical qualifications.

A Professor of Forensic Psychiatry has recently been appointed to the University of NSW. The Committee believes that this appointment will increase the profile of prison psychiatric services, allow the development of a training program in this discipline, and provide additional clinical input to the Prison Medical Service.

11.1 Problems in Service Delivery

Psychiatric services are a crucial component of medical care provided to inmates. The Royal Commission into Aboriginal Deaths in Custody commented

"prisoner mental health care appears to be an area which has received little attention and few resources over the years, despite the fact that a high proportion of the prison population suffer from some form of mental and behavioural problem. The high incidence of suicide and self-inflicted harm is no doubt a reflection of this fact".\(^{(1)}\)

The Committee notes that in June 1991, a comprehensive report on Aboriginal Mental Health was issued.\(^{(2)}\)

Many prisoners present with a range of florid, drug-induced and organic psychoses, and affective, adjustment and other disorders. Health care staff report that prisoners are often intolerant of other prisoners with psychiatric difficulties.

Psychiatric services were severely criticised by many people in discussions with the Committee. Criticisms related to the following issues

(i) **psychiatric hours available**

It is well recognised that the prison population has a high number of people with psychiatric problems, and that the gaol environment itself is inherently stressful. Despite this fact, less than 100 hours of psychiatrists' time per week is effectively available, and this time must also be used for non-therapeutic matters. This is to serve a full-time population of over 6,000 people and arguably more when the transient figure of 20,000 and the population of Periodic Detention Centres is taken into account. Dr. Gluckstern believes that there should be at least one additional psychiatrist and a psychiatric registrar. The Committee agrees that the number of hours of psychiatrists' time available to prisoners is grossly inadequate.
Nurses surveyed by the Committee agreed with this view:

"psychiatric care is totally inadequate. The visiting psychiatrist is excellent but can only visit once a month. (In) recent times we are getting more and more psychiatric patients, for which we are relatively ill-equipped"

"very poor psychiatric service due to the hours for the psychiatrist being dramatically cut by Sydney"

The Committee has been informed of instances where prisoners appear before parole review hearings, and are refused parole on the basis that they have not undertaken appropriate psychiatric or psychological counselling. This may have been because the prisoner was not identified as being in need of such counselling, or because there were not sufficient resources available to allow counselling to be provided.

In the Committee’s view, this lack of service severely compromises the mental health of the prison population. It also means that psychiatrists are unable to spend time on other important matters. Dr. Gluckstein has commented, for instance, that it would be useful for psychiatrists to be able to prepare discharge summaries to provide community psychiatrists with information. This information may help prevent decompensation and recidivism amongst prisoners, but at present there is little time or opportunity to prepare such reports.

Given these demands, staff training and development for psychiatrists receives little attention.

(ii) psychiatric services for female prisoners

There is a marked disparity between psychiatric services available to male and female prisoners. Women prisoners, in comparison with their male counterparts, have few prospects for transfer between gaols and their health needs are disproportionate to their numbers.

Long Bay Prison Hospital is no longer available to women prisoners, although the issue is under discussion by a joint Health/Corrective Services Committee. Cumberland Hospital has six beds for use by female forensic patients. Frequently an order is made under the Mental Health Act for a prisoner to be transferred to Cumberland Hospital, but because beds are not available the transfer does not eventuate. This means that severely psychiatrically disturbed women offenders must be retained at Mulawa prison in the "Rose Scott" Unit. In the Committee's view, this Unit is quite inappropriate and substandard. The physical condition of the Unit is poor and the layout of the Unit is inappropriate for the observation of disturbed patients. The Committee understands that psychiatrically trained staff are not always available to manage disturbed prisoners, which is quite unsatisfactory. The Committee believes that appropriately trained staff should be in attendance at all times when cells
are occupied by acutely disturbed or suicidal patients.

The Committee believes that female prisoners should have access to equivalent services and options available to male prisoners. It also believes that the Rose Scott Unit should be closed immediately.

(iii) *facilities for acutely disturbed prisoners*

An issue which caused particular concern to the Committee was that of the availability of facilities and procedures for observation of prisoners with psychiatric problems.

The Committee was concerned that apart from Long Bay Prison Hospital there was generally no provision for overnight observation of acutely disturbed prisoners by medically trained staff. In some instances, transfer to Long Bay Prison Hospital is possible, but failing that, the only observation is provided by custodial officers positioned outside the observation area on a regular but non-continual basis.

The Committee was informed of one incident where nurses arrived at Bathurst gaol for commencement of a morning shift. An acutely disturbed prisoner had been confined overnight in the ward area of the clinic with no medical observation. Another prisoner who had a heart disorder was also in this area. As the nurses arrived at work, they witnessed the prisoner break a dinner plate and then slash open his stomach, but were unable to gain immediate access to the area as it was locked. Nurses were eventually able to attract the attention of prison officers who had to unlock the area. Had this situation occurred earlier, medical staff would not have been present. The Committee also noted that the ward area had a number of sections not observable by persons outside, and that the physical layout of the ward was such that there were protruding objects (shower fittings, window frames etc.) which could easily have been used by prisoners in suicide attempts. A number of similar problems were documented at Goulburn gaol. Again, there was no procedure for overnight observation of disturbed prisoners by health staff, and physical facilities did not appear adequate for accommodation of such prisoners.

The Director of the PMS advised the Committee that it was "unlikely in the extreme that there will ever be adequate provision for overnight observation in each gaol in the state" due to economic constraints on DOCS supplying an adequate observation area in each gaol, and financial limitations on the PMS. He said that although the PMS would like to be able to provide 24 hour nursing, it was "absolutely fatuous" to attempt to provide such cover at this time, given the present difficulties in providing nursing services.

The Director commented that in some circumstances, nurses have been authorised to work overtime to observe patients overnight pending a transfer, but "needless to say, this is a cost for which we are not compensated and it also raises security issues for Corrective Services". He said:

"You mention the issue at Bathurst when the nurse could not gain the attention of a prison officer. I can relate to you an issue where a prisoner put a noose
around his neck and jumped from his bed in the Long Bay Prison Hospital with a nurse and prison officer watching but nothing could be done as they had to wait for the second prison officer to come with a key to open the cell ........ such are the realities of health care in gaol."

He also noted that

"the cost of implementing a suitable observation area with suitable access outside of totally secured areas and with attendant nursing staff .... would probably lead to capital costs in the hundreds of thousands, if not millions, and a significant increase in staff numbers".

(iv) **transfers to and from the prison hospital**

The Committee has heard of a number of problems relating to transfer of prisoners to and from the prison hospital. These relate to delays, inability to obtain admissions, and lack of notice of transfer given to hospital staff. These are discussed in more detail in Chapter 12.

(v) **psychiatrists’ role in preparation of reports to authorities**

The Committee believes that there is a potential conflict of interest faced by prison psychiatrists who are required both to be involved in a therapeutic role, and to provide reports to the criminal justice system.

Preparation of such reports is also time consuming for psychiatrists. The Director of the PMS has commented

"there is a possibility that we will have to stop doing court reports. With current budget problems, court reports take up an inordinate amount of psychiatrists’ time, and that time could be better spent in therapeutic interventions".

(vi) **difficulties in obtaining psychiatric assistance at community health centres for people who have served prison sentences**

This is reported to be a problem on occasions, particularly where prisoners have committed serious offences.

(vii) **quality of psychiatric services**

In Chapter 7, the Committee has recommended that a position of Director of Psychiatric Services be established.

In the Committee’s view, the employment of a full-time Director of Psychiatric Services would facilitate monitoring and evaluation, and fill an important role in relation to Quality Assurance.
(viii) lack of cohesion

The Acting Director reports that there is a problem of lack of cohesion, because apart from one full-time psychiatrist, the work of 2.2 psychiatrists is performed by 11 part-time practitioners.

(ix) psychiatric screening

Comprehensive psychiatric screening on reception allows for appropriate early intervention and cost savings, and has the capacity to prevent self-harm and suicide. The Committee believes that appropriate mechanisms should be put in place to ensure that prisoners are assessed on reception and referred to appropriate services. At present such assessment is limited. This is discussed in more detail in Chapter 21.

(x) recruitment of staff psychiatrists

The Director of the PMS has commented to the Committee that although there are no difficulties in recruiting psychiatrists to VMO positions, it is more difficult to recruit staff psychiatrists. The Royal Commission into Aboriginal Deaths in Custody stated that this problem was shared by a number of States, and is particularly acute in country areas where access to mental health professionals is even more limited. In this context, the Committee notes the lack of Aboriginal mental health workers in NSW.

The greater use of psychologists and other mental health professionals and the development of therapeutic programs would help to lighten the psychiatrists' load. The development of Gaol Health Teams should also assist with this task.

11.2 Need for Training

As discussed in other sections of this report, additional training for PMS staff and prison officers may also be of great assistance. One nurse commented to the Committee

"Correctional staff do not have the knowledge to deal effectively and fairly with psychiatric patients. They need more training in the area. Many have said they are enthusiastic about this."

Another nurse commented on the inability of some prison officers to distinguish between psychiatric upset and manipulative behaviour on the part of prisoners.

Dr. Gluckstern also supports the provision of training to prison officers in "this area", stating that this would be rewarding, and that tentative steps by nursing staff have led to better understanding by Corrective Service Officers of patients in the psychiatric wards. The Committee believes that Prison Officers should be informed of the availability of services and encouraged to refer prisoners where necessary.
As a general principle, the Committee believes that mechanisms should be established for the monitoring of prisoners' psychiatric progress during the course of their sentences. This is consistent with good clinical practice.

11.3 Responsibility for Psychological Services

It has been suggested to the Committee that psychological services could be more appropriately administered by the PMS, rather than by DOCS, as this would allow a greater focus on health issues. The Committee believes that the development of Gaol Health Teams is an appropriate method to ensure effective delivery of psychological and psychiatric services, in the first instance. If such teams are established throughout gaols, then the issue of where administrative responsibility for psychologists should lie becomes less important.

RECOMMENDATIONS

21. That the Rose Scott Unit at Mulawa be closed immediately.

22. That facilities at Long Bay Prison Hospital again be made available to women prisoners.

23. That all gaols develop safe facilities for the observation of acutely disturbed prisoners, which meet criteria determined by the Board and DOCS.

24. That appropriately trained health care staff be in attendance at all times when acutely disturbed or suicidal prisoners are identified.

25. That the Board urgently review the number of hours of psychiatrists' time available to inmates.

26. That the NSW Institute of Psychiatry or a similar body be approached to develop psychiatric training courses for correctional health nurses.

27. That provision of therapeutic services to prisoners be a priority for PMS staff, taking precedence over other services such as preparation of court reports.

FOOTNOTES


(2) Aboriginal Medical Service Co-operative Ltd, NSW Aboriginal Mental Health Report, May 1991.
CHAPTER 12

12.0 HOSPITAL SERVICES

12.1 Long Bay Prison Hospital

Long Bay Prison Hospital is the main hospital facility for the male prison population in NSW. It is divided into 4 - 30-bed wards, as follows:

A Ward - is purpose built for long term psychiatric rehabilitation. People who were forensic patients under the Mental Health Act 1990 and who required maximum security containment at Morisset Psychiatric hospital were transferred to A Ward on 17 December 1990. For some time prior to this the ward was used as a gaol for young offenders, who at the direction of the DOCS, had displaced other forensic psychiatric patients. In the process, these patients were placed in C ward and the female psychiatric patients then accommodated there were returned to the inadequate facilities at Mulawa.

From 21 December 1990, Ward A and some beds in Ward C have been gazetted as a hospital within the meaning of the Mental Health Act. Under that Act, the Director of the PMS is the Medical Superintendent and the Deputy Director is Deputy Medical Superintendent of the Hospital. The remaining beds in C Ward are available to non-forensic patients. 20 beds are open in Ward A.

B Ward - functions as a medical inpatient facility for the NSW male gaol population.

C Ward - functions as a sub-acute psychiatric unit.

D Ward - is an acute psychiatric admission unit serving the male gaol population.

A number of instances of the use of Long Bay Prison hospital facilities for non-medical purposes have come to the attention of the Committee. For example, the Committee has been informed that the hospital has been used for prisoners who require "protection", but who do not fit the criteria for admission to the high security Special Purpose Prison. PMS staff did not believe that this practice ever jeopardised patient care, but the Committee has some concerns about it. Specifically there have been complaints that the hospital is sometimes full, so that further admissions are not possible. The Committee is concerned that this practice may restrict access to necessary hospital care.

There were complaints about delays in admission to hospital, about the transport and escort systems and about communication problems. There were complaints about delays in the transport of inmates out of the hospital after medical discharge. Evidence about the causes of these problems is conflicting, but there are certainly strong views expressed. The Committee is of the view that this situation should be monitored and the extent of the problem should be evaluated.
Senior executives of the DOCS have questioned whether it is necessary to have prison officers, in addition to nursing staff, in the psychiatric wards of the Long Bay Hospital. A proposal was submitted by DOCS some time ago to withdraw prison officers so that they were only involved in perimeter security and supervision of the gate area. This would bring the psychiatric wards into line with psychiatric hospitals in the community.

The Committee would support the withdrawal of custodial staff to provide only peripheral security for psychiatric wards. Appropriate staffing levels would however have to be guaranteed before this action could be taken. As this would involve transfer of internal custodial functions from DOCS to the PMS, commensurate transfer of funds would need to be negotiated. Procedures which ensure back-up from DOCS staff to hospital staff in emergency situations would also need to be in place. It is acknowledged that some PMS staff have some concerns about this proposal.

The benefit of this approach is that medical, rather than custodial factors can inform priorities in the Prison Hospital.

12.2 Public Hospitals

In addition to the Long Bay Prison Hospital, the PMS also utilises the public hospital system on occasions. There is a "secure ward" at Prince Henry Hospital, staffed by prison officers and health staff, dedicated to care of prisoners who need outside hospitalisation for medical and surgical conditions. Local public hospitals are also used by the PMS, particularly in emergency situations. This necessitates the use of armed prison officers as escorts, and the prisoner is often required to be handcuffed.

The Committee has been informed by nurses, DOCS staff and prisoners of problems arising from the use of public hospital facilities by prisoners. Some hospitals have been reported to be reluctant to accept prisoners as patients. Prisoners attending outside facilities must be accompanied by custodial officers and, depending on their security classification, may also be handcuffed. Long exposure of prisoners to the public in waiting rooms is therefore of considerable embarrassment to the prisoner and cost to the DOCS, even if waiting time is no longer than that experienced by members of the general community.

These problems are particularly acute in relation to female prisoners, who have very limited access to facilities of the Long Bay Prison Hospital and are therefore almost totally dependent on other public hospitals. DOCS staff, and some PMS staff believe there is a need for a secure medical ward for female offenders. Currently in-patient medical treatment for female prisoners requires the use of prison officers 24 hours a day, generally on overtime.

The Committee believes that options available to male prisoners should also be available to female prisoners. In addition, they should have access to special services required by women, such as obstetric and gynaecological services.

The Committee is aware that staff of DOCS believe that greater use could be made
by the PMS of local health facilities, particularly hospitals. They believe that this
would avoid the expense of transfers to the Prison Hospital. The Committee is also
aware that the possibility of closure of the Prince Henry Hospital Annexe has been
discussed.

On the principle of equality of care between prisoners and the general community, the
Committee can see advantages in the use of public hospitals. In reality, however,
prisoners may encounter severe disadvantages in the public hospital system,
particularly in relation to waiting times and exposure to the general public.

Given these difficulties, the Committee supports the continued availability to the PMS
of the Prince Henry Annexe.

RECOMMENDATIONS

28. That except in relation to positions providing external security, the
withdrawal of custodial staff from the psychiatric wards at Long Bay
Hospital be negotiated between DOCS and the PMS, subject to adequate
staffing and funding and following consultation with staff.

29. That the Board determine the optimum arrangements for the provision of
medical services to women prisoners.
CHAPTER 13

13.0 HIV/AIDS SERVICES

13.1 Services Provided

In April 1989, the Departments of Corrective Services and Health conducted a voluntary and anonymous screening program of inmates in three metropolitan gaols, aimed at determining the compliance rate of inmates offered voluntary testing and the logistics of mass testing. Subsequently the Government decided to introduce compulsory testing for inmates and legislation was introduced in May 1990 to allow this testing to take place. Testing was to be accompanied by the introduction of a case management approach involving gaol health teams. These teams were to consist of staff of the PMS including sexual health nurses and DOCS staff involved in psychology, education, gaol custodial administration and welfare. Pre and post test counselling was to be undertaken by nursing staff of the PMS.

AIDS program funds of $208,820 (1990/91) were allocated to the PMS on a recurrent basis to provide services to HIV positive inmates. The Committee understands that STD nurses and a medical officer were employed with this money.

The Deputy Director of the PMS advised that all PMS medical officers delivered HIV-related services as part of their normal duties.

$12,000 was allocated to the PMS in 1989/90 for HIV/AIDS management training for nursing staff. The AIDS Bureau said that it was not clear to what extent counselling skills were developed as part of the program. The AIDS Bureau is not aware of any staff training organised for other members of the gaol health teams.

The Director of Nursing in the PMS advised the AIDS Bureau that STD nurses performed pre and post-test counselling, and were involved in monitoring asymptomatic HIV positive inmates.

Preliminary results from compulsory AIDS testing indicate a prevalence rate of approximately 0.68%. HIV positive inmates in NSW requiring outpatient care are managed in the prison hospital at Long Bay, and if necessary referred to Prince Henry Hospital for specialist treatment. When the PMS is unable to satisfactorily care for inmates, "outside" experts are brought in or inmates are referred out. Women inmates who are HIV positive receive treatment and follow-up from the Westmead Hospital complex. Although the incidence of HIV positivity is currently low, there is uncertainty about the extent to which this will increase. Additional medical care will need to be provided if the incidence increases.
13.2 Problems in HIV/AIDS Services

The main criticism concerning HIV services is the lack of pre and post test counselling being provided to inmates, and the Committee has received a number of complaints about this. Although some nurses have had some limited training with a view to providing some counselling (after blood has been taken but before results are known), little counselling appears to occur. This was to be provided by the PMS on transfer of the funding. In such an important area, the lack of counselling is a serious problem.

In an effort to solve the problem, an arrangement was made with the AIDS Council of NSW to provide counselling. In January 1991 the Aids Council of NSW (ACON) conducted a six week support program for prisoners in the Malabar complex of prisons. ACON stated that education programs for prisoners focused generally on primary preventive education (how to avoid transmission) which was not the main information need of prisoners with HIV. Prisoners instead need information on how to interpret their diagnosis, how to monitor health status, what treatment options are available and how to obtain access to them. ACON reported that prisoners on the program found value in talking to their peers in the prison, and commented on a reduction in the levels of stress and anxiety as a result of its programs.

However the ACON program gave rise to legitimate concerns about confidentiality. It was perceived that prisoners presenting themselves for counselling would be readily identified by other prisoners as HIV positive. This is in contrast to counselling being provided at the clinics, attended by prisoners for a range of purposes.

AIDS testing has also generated extra work for PMS nurses. A member of a Prison AIDS Action Committee stated:

"Since the beginning of compulsory testing, it seems there is not enough staff to allow time for adequate pre and post test counselling with the inmates being tested... the extra workload can be extremely heavy, leaving normal duties rushed and limited."

A prisoner who was a "peer educator" within the prison system advised the Committee that confidentiality was seen as a major issue to prisoners in relation to disclosure of test results. He also stated that prisoners were concerned about the issues of pre-test counselling, counselling while awaiting results, psychological counselling after testing, person to person counselling with a Peer Educator and the fear of ostracism because of testing procedures.

ACON was also concerned about situations where the confidentiality of prisoners was breached or put at risk of such a breach.

The view of DOCS and the AIDS Bureau of the Department of Health is that prisoners who are HIV positive should be integrated with other prisoners.

"This, in combination with care management, is believed to be the best method"
by which the needs of those inmates can be addressed at a local level without discrimination in terms of classification, placement and attendant privileges. Full integration is consistent with the opinion of a large body of experts and community organisations(1).

In contrast, in Victoria, prisoners who are HIV positive are not integrated with the general population. The policy of "reverse integration" in that State means that these prisoners are accommodated with other prisoners who are on special programs, such as prisoners with intellectual disabilities.

The Committee supports the principle of integration as a general rule but also recognises that there may be individual prisoners who prefer segregation. The Committee believes that such prisoners should be allowed to take this option.

13.3 Preventive Measures

As detailed in Chapter 23, the Committee believes that the Department of Health policy aimed at preventing the spread of HIV/AIDS should be adopted in prison. This includes the use of condoms, bleach and needle exchange, and an effective education strategy. The Committee supports the adoption of such measures in gaols.

RECOMMENDATIONS

30. That the Prison Medical Service ensure that counselling is available to all inmates tested for HIV/AIDS, especially for those inmates who are HIV positive.

31. That the Department of Health policy aimed at preventing the spread of HIV/AIDS in prisons be implemented.

32. That the Board ensure that confidentiality in relation to HIV/AIDS is adhered to, in accordance with the policy of DOCS.

FOOTNOTE

(1) Submission to Committee from AIDS Bureau.
CHAPTER 14

14.0 DENTAL SERVICES

14.1 Dental Health of Prisoners

The Committee has established that there is very little epidemiological information about the health status of NSW prisoners. Information about dental health of prisoners is even more difficult to find. There is no regular screening of prisoners to assess the need for dental services, and therefore no data and no capacity for research to be conducted. Indications are, however that just as physical health of inmates is generally poor, so is their dental health likely to be substandard.

Information supplied to the Committee by the Senior Dental Officer for the Victorian Corrections Health Service states

"the demand for (dental) treatment among prisoners is high. In general, they present with neglected mouths and a high caries rate, exacerbated by drug misuse and associated poor dietary habits".

14.2 International Standards

International Standards provide that prisoners should have "access to dental treatment necessary for the preservation of dental health". This raises questions about the extent to which the Prison Medical Service must remedy pre-existing dental conditions. As with other health problems, prisoners often come into custody with problems that are long standing and for which they have not sought treatment in the community. In Victoria, the dental policy for the Corrections Health Service states:

"while the ultimate goal of the service is the total restoration of a functional and aesthetic denition for all prisoners, practical and financial considerations have forced the development of a system of priorities which attempts the equitable distribution of scarce resources. A more realistic description of the aim of the section is the provision of a service which at least matches that available to the disadvantaged members of the general community".

The Committee agrees that while not all dental services can be available to prisoners on demand, dental services as currently provided in gaols fall far short of those available to disadvantaged members of the general community. The Director of the PMS has informed the Committee that he believes "that the Dental Service is the absolute low point of the PMS provision of services to inmates", and dental services in gaols were condemned by all who commented on them to the Committee. It is notable that they were also severely criticised in the 1985 Women in Prison Task Force Report. Senior staff of DOCS are most unhappy with the current level of service, saying that it was "clearly inadequate", and that "while the overall difficulties of public health dental services is acknowledged, greater effort is required to ensure that basic minimum standards are met".
"I find it hard to explain to an inmate who wants a dental check-up that he has to have toothache before he can be seen by a dentist" (Nurse Survey)

"Dental services are inadequate, when you consider the dentist is available only 4 hours per week, for 400 people, and emergencies only are seen" (Nurse Survey)

"The dentist (is available only) 3 hours a week. Today, (24 December) we are booked up to 23 January, which includes urgent toothaches" (Nurse Survey)

The PMS has the equivalent of 2.5 full-time dentists who visit the metropolitan gaols and cover them to some extent. Rates paid to these dentists are low in comparison with earnings from private dental practice, and this is a factor in the difficulty in recruiting staff. Private dentists provide some coverage in other gaols. Payment for these services are not standardised. Some dentists are paid for sessions, and others on a fee for service basis.

Private dentists are reportedly reluctant to work in gaols. This is partly due to factors which affect recruitment of other health professionals to the PMS, such as

- perceived risks of HIV/hepatitis
- low standard of clinics and facilities
- difficult clientele
- concerns about lower professional standards of dentistry in gaols than in private practice.

As with medical services, there are operational difficulties in providing services in a gaol environment. The Director of the PMS comments that "dentists have major access problems because of the lock-up let-go processes in the gaols... We would be lucky to get six hours dentistry from a dentist on an average day".

The Committee believes that these problems are not insurmountable.

14.3 Standard and Level of Service

Partly due to these difficulties, and partly as a cost cutting measure, dental services have been greatly decreased in recent months. This has resulted in long waiting times (up to several months at some institutions) and substantial restrictions on the circumstances in which dental care is available. The Director of the PMS has determined that dental services will only be provided in "emergencies", defined to be "acute pain or infection". This is clearly unsatisfactory, and acknowledged to be so by the Director of the PMS. In contrast, in Victoria, eligibility for treatment is based on length of sentence. The policy is that:
prisoners on remand and with sentences of 18 months or less are eligible for pain relief only. (This amounts to extractions and temporary dressings)

- prisoners with sentences of 18 months or longer are eligible for routine fillings and full dentures

- partial dentures are provided only for those with sentences of three years or more (partial dentures are often required only for aesthetic reasons)

- these criteria are heavily modified for female prisoners as it is felt that their different sentencing pattern and more difficult access to treatment unfairly disadvantaged them.

62% of the prisoners responding to the survey sent out by the Committee had seen a dentist in their time in gaol. 49% of those said they were happy with the service they received.

"The dentist in prison is excellent and I would fully recommend him to anyone"

Many however complained about waiting times.

"Got one filling in 6 years of gaol, told to come back in one month for another but have so far had to wait 7 months and still no action"

"The dentist only comes in once a week and originally it took me 5 months to get my first appointment. The dentist was appalled at the amount of time it took and due to the delay my teeth are in quite a bad state."

Others said they would avoid going to the gaol dentist because of that dentist’s bad reputation amongst prisoners. Several made comments relating to this particular dentist, saying that the wrong tooth had been pulled or dental work had been incompetently performed. Others who were not happy with the service had very strong comments to make.

"Never again. I (would) rather let my teeth rot"

"Inmates suffer verbal abuse, temporary fillings left as permanent, methadone inmates given minimum anaesthetic, a great lack of equipment and supplies"
"Saw dentist at .... gaol. Filling repaired after it had come out. 24 hours later it had come out again. At .... gaol, broke a tooth. After 3 weeks in considerable pain I was told approximately 100 other prisoners ahead of me. My solicitor arranged appointment with a dentist of my choice, authorities refused to allow this and arranged another dentist. I had to wait a further 2 weeks in terrible pain. Finally I was taken. The repair is unsatisfactory and I paid the dentist $65.00"
CHAPTER 15

15.0 DRUG AND ALCOHOL PROGRAMS

Drug and Alcohol Programs provided to inmates are funded as part of the National Campaign Against Drug Abuse (NCADA) "Reduction in Demand" Strategy. The services are provided by Drug and Alcohol Workers employed by DOCS. The terms of reference for this Committee do not expressly extend to a review of Drug and Alcohol programs, although the provision of health services to drug users in custody is within the ambit of the review. Undoubtedly the existence (or otherwise) of such services affects the physical and mental health of many inmates. This is particularly relevant given the high proportion of inmates who have histories of drug and alcohol addiction.

In 1989-90, 278 programs in 7 different areas were conducted as part of the "Reduction in Demand Strategy", to address the issues related to inmates' problems with Drug and Alcohol abuse. These included:

- Drug and Alcohol Counselling, Group Therapy and Education
- Communication Skills
- Life Management
- Fitness and Health
- Stress Management
- Diversionary/Recreation Programs.

In general, drug and alcohol services appeared to the Committee to be viewed favourably by staff of the PMS and DOCS and by prisoners. The Committee was impressed by service development and evaluation mechanisms in relation to these programs, and by the professionalism of the staff involved.

The only reported criticisms related to the lack of availability of drug and alcohol counsellors. Many Superintendents supported the extension of existing programs. It was stated to the Committee that because of the lack of services in some institutions, prisoners have formed their own groups, led by those with experience (but no training) in drug and alcohol counselling.

The Committee believes that incarceration provides an opportunity to target prisoners in relation to problems such as drug and alcohol addiction. This opportunity should be actively taken up, rather than prisoners being relied upon to seek out appropriate help.

As with other services, it is appropriate for community resources to be accessed by the prison population. The Committee believes that groups such as Narcotics Anonymous could be effectively used to conduct groups within gaols, possibly in conjunction with services provided by the PMS.
It was suggested to the Committee that Drug and Alcohol Services would be more appropriately placed within the Prison Medical Service, and that this would allow effective liaison between Drug and Alcohol Counsellors and other medical services, leading to an integrated management plan for individual prisoners.

Staff of DOCS said:

"The possibility of transferring D and A Services to the control of the PMS has been discussed and has some support as this would allow for better integration of the provision of health services, including preventive health services. However, the experience with the methadone program suggests that many of the effective programs developed and implemented by Corrective Services to date may be lost because of the limited administration and planning resources in the PMS."

As with psychological services, the Committee is not opposed to the integration of Drug and Alcohol services into the PMS. However in the short term it believes that the development of Gaol Health Teams will be a first step to assist with this integration. At such time as this integration is achieved, and policy and strategic planning is in place for the PMS, further consolidation of these services in relation to or within the PMS might then be appropriate.
CHAPTER 16

16.0 STAFF EMPLOYED BY THE PMS

The Committee experienced some difficulty in ascertaining the exact number of staff or sessional officers who provide services to the PMS. "Payroll lists" do not necessarily reflect the actual numbers of staff employed at any one time. Other documentation supplied by the PMS show that staff are employed where there is no establishment, while some positions described to be establishment were not filled.

The PMS has an "on paper" establishment of around 160 staff. However, this figure is meaningless in that many of the positions listed have never received approval for funding from the Finance Section of the Department of Health.

16.1 Executive Staff

The Director and the Deputy Director of the PMS are both employed on Senior Executive Service contracts. The incumbents in these positions are both medical practitioners. The PMS also employs a Manager, responsible for finance and administration. A Director of Nursing (DON) and a Deputy Director of Nursing (DDON) are also employed.

16.2 Nursing Management

In addition to the DON and the DDON, four Assistant Directors of Nursing are employed.

Their responsibilities are as follows:

1. Administration of personnel nursing services, coordination of nursing management, communication of policy to nursing staff and administration of country nursing services.

2. Administration of nursing services within Long Bay Prison Hospital; implementation of nursing policy.

3. Administration of evening duty nursing services throughout NSW gaols.

4. Administration of night duty nursing services throughout NSW gaols.

A Nursing Unit Manager is responsible for administration of nursing services throughout Western Metropolitan Gaols.
The following list provided to the Committee by the PMS shows a notional profile of prison nursing staff in NSW as at March 1991.

**Nurses**

The information provided to the Committee by the PMS shows a notional profile of prison nursing staff in NSW as at March 1991. The list includes various roles and levels within the prison system, such as nurses, prison hospital staff, and clinical nurse consultants, among others. The structure of the prison system is depicted in a diagram format, indicating the hierarchical arrangement of the various roles and their responsibilities.
The vast majority of staff employed by the PMS are nurses. The Committee was unable to confirm definite numbers of staff, but it appears from figures supplied to the Committee that there is an establishment of 136 nurses approved by the Department of Health. However, approval for a significant number of these positions was given without a funding source being identified.

A PMS Nursing Establishment Chart for March 1991 shows 15 Nursing Unit Managers, 2 Clinical Nurse Consultants, 10 Clinical Nurse Specialists, 1 Charge Nurse, 118 Registered Nurses, 26 State Enrolled Nurses and 1 Domiciliary Nurse. Not all of these positions are full-time.

Nursing staff are dispersed throughout the State, with some nursing coverage being provided at all gaols. At Berrima gaol, there is a part-time nurse who works only 2 days per week. At larger metropolitan gaols such as the Assessment Prison, the nursing establishment is 6.5. As most of the prison population is in the Sydney metropolitan area most nurses are employed in this region.

PMS nurses may be employed in any of the following areas:

- administrative or executive positions
- in the Prison Hospital
- at gaol clinics
- with specialist services (e.g. Psychiatric Domiciliary or Sexually Transmitted Disease Nursing) as Clinical Nurse Consultant or Clinical Nurse Specialists in this area.

Most nurses employed in the PMS are Registered Nurses, but there are also a number of State Enrolled Nurses employed. There are three gradings for Nursing Unit Managers, based on seniority, responsibility and experience. It should be noted that these Nursing Unit Managers often have a significant management and administrative function.

16.4 Medical Officers

Section 9 of the Prisons Act 1952 provides that the Governor may, on the recommendation of the Minister for Health and with the concurrence of the Minister for Corrective Services, appoint a medical officer for each prison.

The Director of the PMS and his Deputy are both medical practitioners. Although their role is primarily administrative, they both have some clinical responsibility. The Director is the "authorised prescriber" for Methadone, which carries with it clinical responsibilities.

In addition there are 5 full-time career Medical Officers, 4 of whom are based at the Long Bay Complex. The other Career Medical Officer is based at the Western Metropolitan Region. Two psychiatrists are employed at Long Bay.
Specialist and GP services are provided by Visiting Medical Officers (VMOs) who visit prisons on a sessional basis, and provide services such as psychiatry, orthopaedics and gynaecology. Expenditure on VMOs accounts for approximately 10% of the PMS budget.

16.5 Administrative Services Staff

The table on page 78 was supplied to the Committee by the PMS, and shows the organisational chart for administrative services in the PMS.

The domestic services and catering staff employed by the PMS provide services to the prison hospital, which has 120 beds, of which 20 or so are not operational. Given the size of the complex, it may be that the number of people employed in this area is excessive and needs review.

16.6 Dental Staff

Two full-time dental officers are employed at Long Bay Gaol, one of whom provides services on a part-time basis for the Western Metropolitan Region. Two dental nurses are employed at Long Bay.

At other gaols, there is reliance on private dental services, paid on either a sessional or fee-for-service basis. There are no chairside assistants to assist dentists outside the Long Bay Complex, and visiting dental officers are required to provide their own staff to assist with this function.

16.7 Physiotherapists

There is one physiotherapist employed at Long Bay, with one position vacant, and Mulawa Prison has one visiting physiotherapist. As far as the Committee is aware, there is no physiotherapy service to other gaols.

16.8 Psychologists

No psychologists are employed by the PMS. The Committee understands that 34 psychologists are employed by the Department of Corrective Services. Of this number, only 2 have clinical qualifications.
ORGANISATIONAL CHART - PMS ADMINISTRATIVE SERVICES

DIRECTOR - ADMINISTRATIVE SERVICES (GR. 9)

MEDICAL RECORDS ADMINISTRATOR

SUPPLY/TRANSPORT OFFICER (GR. 6)

CATERING OFFICER (GR. 5)

DOMESTIC/SERVICES SUPERVISOR (GR. 3)

FIRST COOK 1

2 x L.H. CLEANERS (H.A.G. 2)

2 x L.H. CLEANERS (H.A.G. 2)

7 x CLEANERS (H.A.G. 2)

6 x CLEANERS (H.A.G. 1)

7WARDSMEN (H.A.G. 3)

O.I.C. (C.A. CLASS 3/4)

STOREMAN (GR. 2)

4 x COOKS

7 x KITCHEN HANDS (H.A.G. 2)

9 x CATER. ASSIST. (H.A.G. 1)

2 x APPRENTICE COOKS

C.A. (CLASS 1/2)

DRIVER/ATTEND

7 x KITCHEN HANDS (H.A.G. 2)

9 x CATER. ASSIST. (H.A.G. 1)

2 x APPRENTICE COOKS

C.A. (CLASS 1)

COURIER/STORES ASSISTANT

FINANCE OFFICER (GR. 5/6)

OFFICER MANAGER (GR. 4)

PERSONNEL OFFICER (GR. 2)

DIRECTORS SECT. (C.O. GR. 3/4)

*CREDITORS CLERK (C.O. GR. 3)

INTERNAL AUDITOR (GR. 1/2)

ACCOUNTS CLERK (C.A. GR. 1)

C.A. (GEN. SCALE) P. F/T

MULAWA

STENOGRAFER

*VACANT - RECRUITMENT ACTION PROCEEDING

*TYPIST

4 x C.A. (GEN SCALE)

C.O. (GR. 1/2)
CHAPTER 17

17.0 STAFF TRAINING AND DEVELOPMENT

The Committee was made aware of a number of issues concerning staff training and development in the PMS. In general, problems reported to the Committee concerned staff development for nurses. Given that nurses comprise a large proportion of PMS staff, it is not surprising that this should be the case.

The Committee did not examine in detail the extent to which continuing education is available to PMS medical officers, physiotherapists or other health care staff, or to others who have interaction with the medical service but who are not employed by it (such as prison officers). For example, a number of people have suggested to the Committee that it would be useful for prison officers to receive training about care of psychiatrically disturbed prisoners. As a general principle, the Committee supports continuing education and training for all staff and believes that it is an important part of their employment. This is consistent with recent Commonwealth legislation mandating continuing staff training. The following relates to staff training and development for nurses.

17.1 Courses Available

The adequacy and availability of staff training and development for PMS nurses was an issue within the terms of reference of the study undertaken by Ms Bernie Closs for the Committee, and the following information draws partly on that report. This section outlines the staff training programs currently available to nurses in the PMS.

(a) Correctional Health Nursing Course

The Correctional Health Nursing Course is the only specialised course designed to meet the needs of nursing staff employed within the NSW prison system. The course is available to registered nurses and jointly funded by the NSW Department of Health and the Commonwealth Department of Education, Employment and Training.

The first Correctional Health Nursing Course commenced in February 1989 through the then Mitchell College of Advanced Education, with a second course commencing in July 1989. The course is of 150 hours duration (the equivalent of one semester). So far, 34 nurses have completed the course. The course is to run again in 1991. Applications to the course are made through the Director of Nursing.

The course is spoken of very highly by nurses who have completed it, and materials from the course suggest that it provides good debate, discussion and instruction in this specialised area. However, Ms Closs’ study reported that "some staff believed the course assumed a background in psychiatric nursing which many did not in fact have".
(b) Orientation Program

Ms Closs' study reported that all new (nursing) staff receive an orientation program conducted at the Long Bay Complex. This course is the responsibility of the Assistant Director of Nursing (Personnel). Ms Closs commented "this program is considered to be invaluable and attendance at it is compulsory".

Not all nurses surveyed by the Committee shared this view about the utility of the course. The surveys asked: "How satisfactory was the training you received for this job? Are there areas in which you would like further training"?

Responses included:

"Most unsatisfactory, if our orientation was improved there may be better staff retention. Because we work within two systems I feel we should have learned Corrective Services' system a little bit".

"Orientation was fairly minimal. Learned as you go along".

"Orientation is lacking - we would benefit more from a week's in-depth orientation".

"Commenced first day with 32 keys, a clinic and 470 inmates".

A Superintendent also commented to the Committee:

"I believe that all medical staff should attend the Corrective Services Academy before commencing duty in the gaol to be instructed in security procedures."

(c) Sexually Transmitted Diseases Course

There is a full-time 6 month course run at the Royal Prince Alfred Hospital, attended by two staff of the PMS in the past year.

(d) Training Course on Clinical Management of HIV Diseases

This course was commenced at the request of the AIDS in Prison Project Manager in the Department of Corrective Services, and was conducted by Dr David Sutherland and Ms Sandy Berenger, HIV/AIDS Infection Control Project Officer at Newcastle Hospital. Previous courses had targeted senior management, Superintendents and staff of DOCS, prisoners, prison hospital staff, probation and parole officers and staff of juvenile detention centres.
A four day pilot program was held for five Nursing Unit Managers in May 1990 and another program attended by twenty five nurses was run in October-November 1990. The program’s aims, objectives and content were approved by the Director of Nursing of the PMS, the AIDS Bureau of the Department of Health and the manager of the NSW Prison AIDS project. The course was funded by a grant from the AIDS Council. The course was on the whole very favourably evaluated by staff who attended it.

(e) Workshops

Ms Closs’ study stated that “workshops have been arranged in AIDS/HIV update and basic counselling. In addition drug and alcohol workshops have been arranged through CEIDA” (the Centre for Education and Information on Drugs and Alcohol).

(f) NSW PMS Nursing Conference

This is a three day seminar held annually by the PMS for nursing staff. The first day is for Nursing Unit Managers and charge nurses, the second and third day for all nursing staff. Sessions of the 1990 Conference were attended by the Committee.

(g) National Corrections Health Conference

The first National Corrections Health Conference was held in Melbourne in March 1991, and was extremely well attended by staff from Prison Medical Services across Australia and New Zealand. There were over 300 people in attendance, 30 of whom were from the NSW PMS. Those present from NSW included administrative and executive staff as well as nurses.

(h) Clinical Nurses Consultants

These people are expected to provide in-service training in their own specialties, but as these positions are relatively new, no educational programs have as yet been developed.

17.2 Problems in Training and Development

The Committee understands that there is no formal staff development program for nursing staff or others. Ms Closs reported that she had discussed with staff their need for in-service training and staff development, and that there was generally an air of dissatisfaction expressed in relation to what is available. A particular complaint was that because of staff shortages, staff could not be released to attend in-service programs.

These views were to a large extent shared by many nurses who were surveyed by the Committee. They referred to the disadvantages of:

"not having continuing education to upgrade our nursing."
and commented:

"We would dearly love to see further education for the staff as the norm not the exception."

"there is never any money to send anyone other than NUMs away for courses."

"Unable to attend courses, seminars and updates ..... either not available or have to pay for them yourself or attend in your own time or only NUMs attend."

Ms Closs stated that the following areas were nominated by nursing staff as those in which they would like further education

- Management
- Psychiatric assessment and helping strategies
- Crisis Intervention
- Sexual Education and Counselling
- Drug and Alcohol
- Stress Management
- Negotiating Skills
- Career Counselling and Advice
- Cardio-pulmonary Resuscitation.

She noted that psychiatric nursing in particular required attention

"In every facility I visited, nursing staff expressed concern regarding the availability of psychiatric services to the prison population. The majority of nursing staff felt that they did not have sufficient skills in this area. They felt that education in psychiatric nursing should be available in view of the large numbers of prisoners presenting with mental health/psychiatric problems."

She recommended that short courses in psychiatric nursing should be made available to staff who have had little or no experience in this area, and commented that this could possibly be arranged in conjunction with Rozelle Hospital.

17.3 Responsibility for Staff Development and Study Leave

Ms Closs reported that the Director of Nursing, the Deputy Director of Nursing and the Assistant Director of Nursing encourage staff to undertake formal education in outside colleges, but only a small number of selected staff were granted leave to attend. Her report recommended:
"One individual should be given responsibility to oversee staff development and to ensure that staff are released to attend as necessary."

Ms Closs also stated that there does not appear to be a standard policy on study leave, but that staff had requested the development of a written policy and Ms Closs recommended that this occur. She stated that applications for study leave are usually refused because of funding problems.

The Committee understands that the public service standard policy on study leave applies to nursing staff in the PMS. This provides that study leave should be encouraged but that it is subject to the convenience of the employer. Given the shortage of staff in many gaols and the high workload it is often difficult for staff to be granted study leave or time to attend other courses.

The Committee became aware that there is some dissatisfaction in the PMS about how study leave is allocated, and a perception that it is not always granted equitably. For example Ms Closs reported complaints from some staff that their applications to attend courses were ignored. They were also concerned that there was little information on courses available, study leave or procedures for applications for courses.

17.4 Training in Aboriginal Health Issues

The Royal Commission into Aboriginal Deaths in Custody commented:

"It would appear that in no jurisdiction do staff of the PMS receive any specific training on Aboriginal health or cultural issues, even in those areas with a high Aboriginal population. By contrast, many police and corrections authorities throughout the country have recognised the importance of training at least in the area of Aboriginal culture and lifestyle for their officers and have included this as a component in recruit training courses. It seems to me that it is equally important for medical and health professionals to receive training in this area."

The Committee supports these comments.

17.5 Education In Relation to HIV/AIDS

The Committee is aware of the importance of education in relation to HIV/AIDS for people in the prison system.

The NSW Department of Health and the DOCS AIDS project have worked together to provide education programs which are jointly funded. These programs aim to educate staff of DOCS to manage the AIDS issue effectively and humanely and to educate prisoners in HIV/AIDS prevention.

These programs include:

- information sessions for staff and prisoners at every institution.
AIDS action committees at every institution, which themselves develop educational strategies.

Officer Training Programs.

Peer Education Programs (e.g. specially adapted programs for Aboriginal prisoners and for prisoners with an intellectual disability).

The Committee supports the continuation of these programs.

17.6 Conclusion

The Committee's view is that there is clear need for extensive staff training and development within the PMS at all levels. In addition there is considerable scope for further education for others involved with the PMS such as prison officers.

The Committee believes that there is a strong need for psychiatric training, and for health staff to be able to attend courses which will allow them to maintain vital clinical skills. The Committee also believes that it will be most important for nursing staff to receive management training to prepare for devolution of responsibility to local levels.

Such training will provide benefits for the client group and for the staff themselves. It will also have long term benefits for the Prison Medical Service, as the need for referrals will decline if needs can be met as they arise at the local level.

RECOMMENDATIONS

36. That the Board review the availability of training for all PMS staff, and develop a plan for continuing staff education.

37. That PMS nurses be encouraged to attend the Correctional Health Nursing Course.

38. That an orientation program be developed which will ensure that all staff are adequately familiarised with custodial and health issues relevant to providing health services in gaols.

39. That Nursing Staff receive appropriate training in psychiatric assessment and management.

40. That training be conducted to ensure that health care staff are familiarised with health needs of Aboriginal prisoners and other prisoners with special health needs.

41. That annual updates be provided for nursing staff on emergency procedures, including cardio-pulmonary resuscitation.
42. That staff receive relevant management training prior to devolution of responsibility to local areas.

FOOTNOTE

CHAPTER 18

18.0 GROUPS WITH SPECIFIC NEEDS

Within the prison population there are a number of distinct groups with specific health needs above and beyond those of the general prison population. The following section describes some of the characteristics of these groups and how these characteristics influence their need for health services.

18.1 Women Prisoners

The 1985 Women in Prison Task Force\(^\text{1}\) commented:

"the most striking feature of women's imprisonment, compared to men's imprisonment, is that of scale; in NSW, only 1/20th of the prison population is female and this is a feature mirrored both in other States and internationally."

It noted that in 1985:

- 30.8% of the women interviewed were on remand, compared to 14.6% of the male population;

- significantly fewer women than men are in prison as a result of crimes of aggression against the person (15.3% of the female prison population compared with 25.1% of the male population) and fewer women are in prison as a result of serious property crime;

- a higher percentage of women than men are serving short sentences;

- the majority were between 18 and 30 years of age, with two thirds (66%) aged between 21 and 29 years.

- 78% stated that they were drug or alcohol addicted;

- a higher percentage are on use/possess drug charges than men (9.3% as against 2.4% of men);

The rate of imprisonment of women is increasing and this will result in demands for increased services. In the general community, women are greater consumers of health services than men, and this pattern can be expected to be duplicated in the prison environment.

Women prisoners have needs for obstetric and gynaecological services. As many have a history of sexual abuse, they frequently have strong preferences for health services to be provided by female staff.
The provision of medical services to women prisoners is discussed in Chapter 12.

18.2 Aboriginal Prisoners

Although Aboriginal and Torres Strait Islander people comprise only 1.4 per cent of the general Australian population, at the time of the 30 June 1986 National Prison Census they represented 14.5 per cent of the national prison population, with a rate ratio of ten to one. That is, in proportion to their population, Aboriginals are ten times over-represented in the prison population. In NSW, Aboriginal Australians were 1.1% of the NSW population, but 8.2% of the State’s prison population, with a rate ratio of seven to four.\(^2\)

The Interim Report of the Royal Commission into Aboriginal Deaths in Custody stated:

"....... not only are Aboriginal people being detained in prisons and police cells to an extent grossly disproportionate to their numbers in the general population, but that they are, as a group, significantly at greater risk of becoming ill or dying during their incarceration."\(^3\)

The proportion of Aboriginal prisoners to non-Aboriginal prisoners is also increasing. Aboriginal prisoners often arrive in gaol in a worse state of health than other prisoners, and they have health needs which may be quite different from others. They often have chronic health problems such as heart disease, hypertension and diabetes. In addition they may be reluctant to draw on medical or other services run by predominantly white staff, which results in little or no effective access to the health care needed in gaol. A submission to the Committee from the Aboriginal Medical Service advised that Aboriginal mental health is under constant strain in the community. The level of distress for people in prison is likely to be higher. Yet there are few acceptable or appropriate mental health services for Aboriginal people in the community, and even less within the prison system.

A recent study by the Australian Institute of Health\(^4\) found that Aborigines and Torres Strait Islanders are the least healthy identifiable population group in Australia, and that by virtually every health status measure, and for almost all disease categories, the health of Aborigines is much worse than that of other Australians. Specifically:

- diabetes mellitus is between 2 and 5 times more prevalent among Aborigines than other Australians.

- Aborigines are admitted to hospital two and a half to three times more frequently than other Australians.

- death rates from circulatory diseases, including ischaemic and other heart diseases, are more than twice those of other Australians.

- death rates from diseases of the circulatory system are six to eight times that of other Australians.
The study also says that "the most striking specific aspect of Aboriginal mortality is the very high rate of deaths in young and middle aged adults".

The provision of medical services to Aboriginal prisoners is discussed in Chapter 19.

### 18.3 Drug Users In Custody

The Programmes Division of DOCS recently prepared a research paper on drug and alcohol, which contained the results of a study of 182 inmates received into prison over a two week period from 26th April to 9th May, 1990. The interviews were conducted at the main reception gaols within NSW.

The study reported that 32% of inmates stated that they were experiencing, or expected to experience, withdrawal from alcohol or other drugs upon being imprisoned. 46% of inmates stated that they were dependent on alcohol or other drugs. Almost half of the sample stated that they would like treatment (for drug and alcohol problems) while in gaol.

Drug and Alcohol Services are discussed in more detail in Chapter 15.

### 18.4 Older Prisoners

Most prisoners are young men, but the proportion of older prisoners is increasing, bringing with it a need for increased health care. Research has suggested that prisoners over 50 are particularly affected by factors such as overcrowding in gaols.

### 18.5 Prisoners with Intellectual Disabilities

An empirical study assessing the prevalence of intellectual disability in NSW indicated that the "baseline estimate" was 12% to 13% of the prison population. The figure for the general population is around 3%. The study found that social and adaptive skills were low, especially in the communication area, with some inmates functioning at a level of below 5 years of age.

Historically, the special needs of people with an intellectual disability have tended to be met by medical services, in particular by nurses trained in mental "retardation". It is now recognised that these needs are better met by services with an educational, rather than a medical focus.

Prisoners with an intellectual disability have a limited range of coping mechanisms and hence are particularly vulnerable to stress. This may lead to psychiatric or behavioural problems. Early identification of such prisoners at reception to prison allows for this vulnerability to be flagged and for there to be early intervention with appropriate services. This should assist in reducing psychiatric and psychological morbidity and hence the load on the PMS.

The Committee understands that an inter-departmental committee including representatives of DOCS, Probation and Parole, the PMS, FACS and the NSW Council
on Intellectual Disability, has been working on the development of a policy on prisoners with an intellectual disability. The Committee believes that development of such a policy should be a priority.

18.6 Prisoners with HIV/AIDS

A diagnosis of HIV/AIDS generally results in severe psychological and social trauma for the person diagnosed. Anxiety and uncertainty about the disease and its treatment, new or recurring physical symptoms, low self-esteem, grief and anger are quite common, and the psycho-social impact of HIV/AIDS is likely to be exacerbated by imprisonment, where the prisoner is physically separated from social supports of family and friends. Prisons are generally tense environments and access to psycho-social supports (counsellors, social workers, peer groups and clergy) is restricted and provided within a strictly controlled regime.

Initial results of compulsory HIV testing within prisons has revealed an HIV positivity rate of around 0.68%. Inmates who develop HIV/AIDS will have needs for additional medical services, as well as psychological and/or psychiatric counselling and support. Prisoners who test HIV positive will also generally require counselling. This issue is discussed further in Chapter 13.

18.7 Prisoners of Non-English Speaking Background

Information from the Research Division of the Department of Corrective Services indicates that around 15% of prisoners were born in countries where English is not their first language. Although this does not necessarily mean that these prisoners will have difficulty with the English language, there is a reasonable likelihood that they will experience communication difficulties. In addition, different cultural values may affect their attitudes towards illness and dealing with the health system. This requires staff to have a sensitive attitude towards prisoners from other cultures and to be aware of the need for interpreters in some situations. The Committee also believes that there is a need for cultural awareness and training to facilitate working in a multi-cultural environment.

18.8 Forensic Patients

Forensic patients include those found "not guilty on the grounds of mental illness", those prisoners found unfit to be tried and those who become mentally ill while in gaol. There are up to 30 forensic patients within the prison system at any one time. Psychiatric care is of vital importance to prisoners in this group. This is discussed further in Chapter 11.

18.9 Prisoners at risk of suicide

Perhaps one of the greatest tragedies that can occur in gaol is the deliberate taking of a person's own life. Sadly, this phenomenon is not uncommon. Between 1980 and 1988 in Australia, 265 people died in prison, 34 of whom were Aboriginal. Of those who died in "custody" (as defined by the Royal Commission Into Aboriginal Deaths
in Custody) 190 were found by the Coroner to have committed suicide. This definition included both police cells and prisons. In NSW, 129 people died in "custody" over the same period of which 39 were suicides. In 1989-90 there were 15 suicides in NSW prisons.

This can be contrasted with the situation in Victoria. In that State, the number of deaths in prison was reduced from an average of 6 or 7 per year to none between 1988 and the present time. (See Chapter 21)

The Royal Commission focused attention on Aboriginal deaths, but a significant number of non-Aboriginal people also die in prison each year. The causes of such deaths are complex, but the effects are clear; stress is placed on family and friends, on other inmates and on staff. This issue is of great concern. The PMS has a responsibility to play an important role in the prevention of such deaths.

**18.10 Juveniles**

A small number of juveniles is detained in adult gaols. The second part of this report deals with medical services provided to juveniles detained in juvenile justice institutions. These institutions were until recently run by the Department of FACS, but administrative responsibility for them has since been transferred to DOCS. Specific needs of juveniles are referred to in that section of the report.

**RECOMMENDATION**

43. That the Board review the availability of trained interpreters to facilitate the provision of appropriate health care services to prisoners of non English-speaking background who require them.

44. That continuing education for staff in the PMS encompass training in working in multicultural environments.

**FOOTNOTES**


5. Information supplied by Programmes Division of DOCS.


(9) ibid.

CHAPTER 19

19.0 MEDICAL SERVICES TO ABORIGINAL PRISONERS

Provision of medical services to Aboriginal prisoners is an issue of particular importance to the Committee, given that one of the main reasons for the review was related to the findings of the Royal Commission into Aboriginal Deaths in Custody.

19.1 Services Provided to Aboriginal Prisoners by PMS

As previously detailed, the gaol population contains a disproportionate number of Aboriginal prisoners, and their overall health status tends to be lower than that of the general community. Although this factor may be expected to lead to increased demands on the PMS, there are other countervailing factors such as the lack of Aboriginal staff, which militate against Aboriginal prisoners approaching the service.

The Director of the South Australian PMS has commented

"It is our experience that Aboriginal prisoners in general tend to be less communicative about their health and emotional problems, and are less likely to make use of health and support services available to them in prison. They are also more likely to be less compliant to the treatment recommended to them. This is despite the fact that they often have multiple health problems". (1)

The Committee believes that this comment is equally valid in NSW.

The report of the Royal Commission into Aboriginal Deaths in Custody focussed attention on some Aboriginal health issues in prisons. The Royal Commission also referred to the need to divert Aboriginal people from the gaol system as far as possible. The Committee agrees that this is a very important issue which, if positively addressed, would have a direct effect on the Aboriginal population and on the Prison Medical Service.

The Royal Commission also emphasised the importance of an effective reception and health screening process. The Committee believes that such a process is most important, and forms a crucial element of a total health care program for Aboriginal prisoners.

There are no specific health programs run by the PMS for Aboriginal prisoners. The Director of the PMS comments on this point:

"the Aboriginal Medical Service visits as required or as they are available. Certainly we do not have the staff to take on specific Aboriginal issues".

There is general co-operation between the independent Aboriginal Medical Service at Redfern and the PMS. Again, the Director comments:
"the Aboriginal Medical Service is as involved in this Service as it is able to be. It is not an access block, it is purely and simply a matter of their inability to service the prison client group due to their size".

19.2 Services Provided by Aboriginal Medical Service (AMS)

The Committee was fortunate to receive a submission from the Aboriginal Medical Service addressing a number of relevant issues. Much of the following information is based on that submission.

The Aboriginal Medical Service is an independent organisation based at Redfern and employing a number of Aboriginal Health Staff. Many health visits are conducted with health workers and trained counsellors working together.

Since the Aboriginal Medical Service began operation in 1971, the Aboriginal community has voiced its concern for the well-being of Aboriginal people in prisons, often requesting that more visits, assessments and clinics be provided by AMS personnel.

Since 1978, the AMS has provided a regular counselling and primary health care service to Aboriginal people in Long Bay Gaols. Clinics have also been established on a regular but infrequent basis at Parramatta, Parklea and Silverwater prisons although no regular service is provided to any women's prison.

In addition to the clinics, the staff of the AMS are occasionally asked to attend a prisoner because of exceptional circumstances, following requests from a prisoner, his or her family or from a counsellor from the Aboriginal Legal Service. These visits allow Aboriginal people to see an Aboriginal health worker who is independent of the Prison Medical Service and the Department of Corrective Services, and whom inmates feel they can trust.

However the primary responsibility of the AMS is to the clinic at Redfern. As the AMS does not have resources set aside to provide a service to the prisons, staffing problems at Redfern may lead to cancelled prison visits.

Consultations by Aboriginal Prisoners with AMS doctors and counsellors may be for a number of reasons:

- general medical, surgical or sports injuries
- requests for sedatives
- difficulty with sleep
- stress
- need for supportive counselling from someone not directly associated with the gaol
- interviews for court reports
- non medical matters such as information about relatives or about legal matters.

A central concern of the AMS is the need for Aboriginal health workers skilled in
counselling in relation to coping with stress and dealing with other mental health issues. There is also a need for effective health education programs to be conducted in the culture of the recipients.

The AMS advised the Committee that its staff enjoy a co-operative relationship with the Prison Medical Service personnel but that there is no formal mechanism by which they are alerted if Aboriginal people are sick or distressed. In addition they have no "say" in the management of Aboriginal people within the system. The AMS also complained of a cumbersome system of referral and investigation, difficulties in obtaining old records at Long Bay and difficulty in obtaining specialist services at some gaols, thus requiring transfer of prisoners to Long Bay.

The AMS recommended that Aboriginal health workers be available to work as educators and counsellors in every prison where there is a significant population of Aboriginal people. They could assist in the development of an Aboriginal health worker counselling service, and encourage health education and promotion programs on drug use, sexually transmitted diseases, "safe sex" and protective behaviours, diet and fitness etc. In addition their presence would help educate Corrective Services employees on Aboriginal issues.

The Committee notes that the valuable role performed by the Aboriginal Medical Service is currently without remuneration from either the Prison Medical Service or the Department of Health. The Committee’s view is that just as other specialist services are obtained by the PMS on a fee-for-service basis, Aboriginal Medical Services should also be paid for providing services.

19.3 Royal Commission Into Aboriginal Deaths in Custody - Interim Report

As detailed in Chapter 2 of this report, the Interim Report of the Royal Commission into Aboriginal Deaths in Custody recommended:

- that comprehensive medical histories for prisoners be obtained

- that the PMS be independent of DOCS

- that there be twenty four hour access to medical practitioners

- that there be instructions encouraging police/prison officers to seek medical attention for detainees

- that resuscitation equipment be available at prisons

- that there be consultation between Corrective Services, the PMS and Aboriginal Medical Service.

With the exception of the third recommendation, the Committee has no hesitation in supporting all of the above. In relation to this third recommendation, Mr Justice Muirhead said:
"In prisons, whatever the security category, there must be a permanent medical presence, at the least, represented by a trained nurse. By permanent, I mean 24 hours per day, seven days per week. The seriousness of a medical condition should not be left for determination by a person other than a professional health worker. In the context of Police Lock Ups, medical practitioners should be available on call, day or night".\(^2\)

The Committee believes strongly that it is important to have medical practitioners available on call on a 24 hour a day basis. This is the position in all gaols in NSW. As with the general community however, it is not always practical to have a 24 hour medical presence. The Committee believes this is neither necessary nor economically feasible.

19.4 Royal Commission Into Aboriginal Deaths in Custody - Final Report

In May 1991 the Final Report of the Royal Commission into Aboriginal Deaths in Custody was released. It made 45 recommendations relating to custodial health and safety. Many of these recommendations relate to the Police Service and DOCS, and are therefore outside of the terms of reference for the PMS Review Committee. Recommendations relevant to this Committee are listed in Appendix E.

The Committee agrees in general with the relevant recommendations of the Royal Commission. A number of principles embodied in the Commission’s recommendations have been addressed by the Committee in this report, including

- the development of protocols for transfer of information between the police and Corrective Services (Royal Commission recommendation 130; Chapter 21 of this Report)

- equality of health care between people in correctional institutions and those in the general community (Royal Commission recommendation 150; Chapter 1)

- medical services in gaols to include medical, dental, mental health and drug and alcohol services (Royal Commission recommendation 150; Chapters 10, 11, 14 and 15)

- adequate resourcing of health services and employment of appropriately qualified and competent personnel (Royal Commission recommendation 150; Chapter 8)

- accessibility of services to Aboriginal prisoners (Royal Commission recommendation 150; Chapter 19)

- referral of Aboriginal prisoners to appropriate psychiatric care (Royal Commission recommendation 151; Chapter 11)

- involvement of Aboriginal Health Services (Royal Commission recommendation 152; Chapter 19)
ongoing review of Prison Medical Services (Royal Commission recommendation 153; Chapter 7)

- training of PMS staff in Aboriginal issues (Royal Commission recommendation 154; Chapter 17).

The Royal Commission also recommended that Corrective Services, in conjunction with Aboriginal Health Services and other bodies as appropriate review the provision of health services to Aboriginal prisoners in correctional institutions. (Recommendation 152). The Committee supports the recommendation that services to Aboriginal prisoners be reviewed. The Committee believes however that this review should be organised by the PMS Board, as a matter of high priority.

The Committee believes that health services in gaols should be appropriate and accessible to Aboriginal prisoners. As far as possible, Aboriginal prisoners or detainees requiring medical assessment or treatment should be referred to practitioners with knowledge and experience of Aboriginal persons. The Royal Commission into Aboriginal Deaths in Custody made the same comment in relation to psychiatric assessment and treatment. The Royal Commission commented that medical practitioners who are, or who have been employed by Aboriginal Health Services would have experience and knowledge benefiting inmates requiring psychiatric assessment or care, even if they were not specialists in psychiatry.

In addition, the Committee believes that the PMS should as far as possible attempt to recruit Aboriginal staff. The Royal Commission commented that the employment of Aboriginal persons, particularly as nurses and health workers, would greatly enhance the acceptability of Prison Medical Services for Aboriginal prisoners.

Other recommendations made by the Royal Commission related to such issues as the training of prison officers in relation to medical matters. The Committee supports these recommendations.

It should be noted that the Royal Commission recommended that all prisons and police watch-houses should have resuscitation equipment of the safest and most effective type available in the event of emergency, and staff who are trained in the use of such equipment. In addition all police and prison officers should receive basic training in resuscitative measures, and should be trained to know when it is appropriate to attempt resuscitation.

The Committee agrees with these recommendations and believes that they should also apply to PMS staff.

RECOMMENDATIONS

45. That Aboriginal medical services be approached to provide sessional medical services to Aboriginal prisoners on a contractual basis.

46. That the Board, as a matter of priority, organise a review of the provision
of health services to Aboriginal prisoners.

47. That the Prison Medical Service investigate ways to facilitate the recruitment of Aboriginal staff to the Service.

FOOTNOTES

(1) Submission to Royal Commission Into Aboriginal Deaths in Custody, quoted in Final Report of Royal Commission, p.265.

(2) Royal Commission Into Aboriginal Deaths in Custody, Interim Report, p.55.
CHAPTER 20

20.0 THE PRISON METHADONE PROGRAM

20.1 Prison Methadone Programs in other States

Apart from NSW, other States of Australia and overseas jurisdictions offer at the most only limited Prison Methadone Programs. Places on these programs are available to those in specific groups such as pregnant prisoners, prisoners on remand and prisoners who request to be placed on the program shortly before release. The Committee was informed that the only exception to the above is the gaol on Rikers Island, New York, where there is a comprehensive program.

20.2 Background to the NSW Program

In NSW, the Prison Methadone Program is administered at a cost to the Department of Health of approximately $500,000 per year. In addition, there are further costs to the DOCS due to security and operational considerations.

In the general community, methadone programs have provided an approach to treatment of opioid dependence for around 25 years. The principal aim of the program is to assist opioid dependent persons improve their health and social functioning and alleviate the adverse social consequences of their drug use by reducing and eliminating their illicit opioid use. It is also intended to complement strategies to minimise the risk of transmission of the Human Immunodeficiency Virus amongst intravenous drug users and from them to other members of the community. Specialist methadone programs are established with the aim of improving the health of pregnant opioid users and their babies. Community programs operate with varying levels of intervention. However, even programs which operate with minimum levels of intervention provide support and supervision to participants on the program.

The application of the principle that medical care provided to prisoners should be equal to that available to the rest of the community supports the establishment of the program in prisons. Guidelines prepared by the Directorate of the Drug Offensive (DODO) state that the management of individuals on the Prison Methadone Program will, as far as possible within a correctional system, adhere to the policies and procedures for community methadone programs.

In April 1986, a pilot pre-release Methadone program was established within the NSW prison system. It was funded by the National Campaign Against Drug Abuse (NCADA) through the then NSW Drug and Alcohol Authority. The target group was inmates nearing release with a history of opiate addiction. The pre-release program was expanded in late 1987 and became what is now the NSW Prison Methadone Program.

With the expansion of the program came a number of changes to the policy and acceptance criteria. For example, methadone became available to more people in
more NSW gaols, and more community methadone dispensing units became available to inmates on their release. The expanded program encompassed prisoners on methadone at the time of incarceration, long term prisoners and prisoners who were HIV or Hepatitis B virus positive, as well as pre-release prisoners. Currently around 600 prisoners (10% of the prison population) are on the program.

The program was administered by the DOCS until 1 July 1990. Until that time methadone was prescribed by Medical Officers employed by the PMS, but other tasks associated with the program (assessment, counselling etc.) were performed by methadone case workers employed by the DOCS. Methadone was, and continues to be, dispensed by PMS nurses. From 1 July 1990 the program has been administered by the Department of Health through the PMS. A proportion of the latest allocation has been utilised to employ a Project Officer to evaluate the program.

This transfer of the methadone program was effected for a number of reasons: the division in responsibility was seen as artificial, and it was believed that provision of the service by a single organisation would be more cost effective. Nurses who previously only dispensed methadone could be involved in assessment and counselling of inmates.

20.3 Rationale for the Program

The objectives of the Prison Methadone Program, as stated in DODO guidelines, are:

- to reduce the incidence of intravenous heroin use by prisoners
- to reduce the spread of HIV and Hepatitis B among prisoners
- to continue methadone treatment of prisoners incarcerated during treatment
- to commence the methadone treatment of prisoners who are suitable for this treatment
- to facilitate transfers of methadone treatment from the Prison Methadone Program to Community Methadone Programs.

The PMS states that in the prison setting, the main reason for the large scale introduction of methadone is the acknowledgment:

"that in prison in NSW, needle sharing is common and a high-risk activity predisposing to the rapid spread of HIV. It is hoped that by the widespread availability of Methadone in gaol, there will be a reduction in the potential number of inmates who could become HIV antibody positive as a result of imprisonment".

20.4 Risk Taking Behaviour in Gaols

A study was recently conducted of 209 male drug injectors who had spent more than a month in prison. The subjects had been released from prison for just over 2 years at the time of the study, so the mean time of their prison experience was 1987. The results of the study suggested a "disturbingly high" level of high risk behaviour for HIV in prisons. Of 209 respondents:
- 100 -

- 74.2% reported having injected drugs at least once in prison, with heroin being the major drug reported
- 10% of those who injected heroin did so on 16 or more occasions
- 47% of the sample described access to bleach as quite hard, or impossible
- 13% reported having had sex with a man while in prison
- 30% reported having received drug treatment in prison, and 37% of that sample had participated in the methadone program
- 43% said they had not received any information about AIDS while in prison.

The study acknowledged that the prison experience being described in the study was predominantly 1985 to 1987, and that conditions in NSW gaols may have changed since that time. It concluded however that injection equipment is frequently shared, inadequately cleaned and probably shared with a larger number of people than in the non-gaol community. It stated

"what is required from a public health standpoint is to reduce the proportion of prisoners who participate in unsafe injecting or sexual behaviour, to reduce the number of episodes per participating prisoner and to reduce the degree of risk per episode of high risk behaviour." (4)

The Committee believes that a Prison Methadone Program has the capacity to assist in achieving these aims.

20.5 Level of HIV Infection in Gaols

Compulsory HIV testing was introduced in NSW in 1990. Since November 1990, all new receptions have been tested. As of 14 April 1991, 3,671 prisoners had been tested, and of these, there were 25 who tested positive. This is an infection rate of .068%. A further 25 prisoners had refused to be tested.

20.6 Administration of the Program

The Poisons Act 1966 sets out the legal requirements for methadone programs. Section 28 of that Act provides that no medical practitioner may prescribe methadone for a person known or believed to be an opioid addict without an authority from the NSW Department of Health. Where such an authority is granted it may be subject to conditions imposed by the Department of Health.

The Directorate of the Drug Offensive has prepared policies and procedures for the Methadone Treatment of Opioid Dependence in NSW. These guidelines contain a section on the NSW Prison Methadone Program. These guidelines are supplemented by directions to PMS nurses in the PMS Policy Manual, compiled by the Director of the Prison Medical Service. The national guidelines recognise that criteria used to
assess prisoners for the Prison Methadone Program may differ from those in community programs.

The PMS policy manual provides that admission to the program is by written application from the inmate through the clinic, the Deputy Superintendent's Office, the Director of the PMS or the co-ordinator of the Methadone program. The manual provides that methadone assessors then interview the applicant. If criteria are met, the applicant is required to sign an agreement on which entry to the program is requested. The inmates also acknowledge the rules of the program, and that the result of breaking these rules is eventual removal from the program. PMS policy states that after three breaches, dose reduction is usually commenced, but if a breach is sufficiently significant, one breach is sufficient for removal from the program.

In an attempt to ensure compliance with rules prohibiting continuing drug use, random urine samples are collected regularly from those on the program.

The view of the PMS is:

"that while control of the program is extremely important for reasons of safety, amongst others, the main reason behind the Prison Methadone Program is to keep people on rather than find reasons to remove them from the program". (5)

20.7 Involvement of other PMS Staff

The Director of the PMS is the authorised prescriber for the program and nursing staff are involved in dispensing methadone. There is also a clinical nurse consultant employed to work on the methadone program located at the Long Bay Complex. She provides consultancy and education services to all PMS staff in the State on methadone issues.

20.8 Evaluation of the Prison Methadone Program

The Research and Statistics division of the DOCS has carried out a number of studies since the commencement of the pilot program in 1986. These studies have examined issues such

- the effects of the Prison Methadone Program on Criminal Recidivism and Retention in Methadone Treatment
- views of recidivists released after participating in the Prison Methadone Program
- profile of those assessed for the Pilot Pre-release Methadone Program.

At the request of this Committee, DODO has prepared a briefing paper which addresses the history, rationale, effectiveness and evaluation of the Prison Methadone Program. This paper is attached (Appendix F). It comments that the above DOCS studies were:

"interesting, but inconclusive as to the effectiveness of the program in
achieving objectives, as there are flaws in the design and methodology of each'^{14}\)

In measuring the effect of methadone on recidivism, for instance, it is necessary to control for dose variation, the history of criminality in each individual, the period of incarceration and social economic and physical factors.

DOCS and DODO are currently carrying out a study which will attempt to compare the program before and after 30 June 1990. The study should provide a basis for detailed review of the methadone program and develop some research questions for the new administration. The study will examine the perceived aims of the program, the mechanics of methadone dispensing, the adequacy of treatment protocol and the management of prisoners in the context of the methadone program. DODO staff believe that this study should be capable of establishing any management problems. The study is due to be completed by August 1991.

20.9 Problems with the Prison Methadone Program

There are two central issues of concern to the Committee in relation to this program; firstly, whether the benefits of the program justify the considerable expenditure of funds and other resources, and secondly, whether the current program is administered in accordance with policies and guidelines which allow any benefits to be obtained.

Staff of various groups (Superintendents, nurses, drug and alcohol workers and executive staff of both departments) have expressed serious concerns about the Methadone Program. Few, if any support the continuation of the program in its current form. Ms Closs reported that many nursing staff interviewed by her were opposed to the methadone program, as they found it to be work intensive and demanding, and a cause of stress. She stated that they felt they were "being used to provide a legitimate drug service" to prisoners.

The Committee found little support for the program from staff of DOCS, and there was in fact strong opposition to it in some quarters. They believed that the program was "a good example of the difficulties in reconciling the goals of Corrective Services and the PMS" and that "correctional institutions should be drug free". DOCS staff also referred to the operational difficulties which the program presents for them: inability to transfer prisoners to lower security gaols which do not have the program, security problems ("standovers" etc) and demands on their time (the 15 minute "hold" period following ingestion of methadone). This "hold" period is imposed as a requirement of DOCS, not the PMS.

Although some believe that the methadone program has a legitimate role in a comprehensive treatment regime, there is concern about the capacity or likelihood of the program to meet its objectives under current conditions. Questions are raised as to whether the objectives can be met and whether money spent on the program is effectively used.

Staff of DODO advised the Committee that an effective methadone program should
consist of:

- assessment
- dosing services
- counselling and/or casework
- HIV education/information education strategies
- monitoring and review procedures
- quality assurance mechanisms.

The main concerns about the program are outlined below.

(a) Criteria for Entry

The National Methadone Guidelines provide that methadone should only be available after a thorough physical, social and psychological assessment, and in general, physical dependence should be regarded as a prerequisite for admission to a program. It also says that serious consideration should be given to some other forms of treatment for those in younger age groups. At present assessment appears to fall short of the established policy.

(b) Criteria for Removal from Program

Under the contract between the prescriber and the inmate, misbehaviour by the inmates (use of other drugs, abusing staff etc.) can result in being "breached" and then removal from the program. The final decision regarding removal from the program lies with the prescriber (the Director of the PMS) or his delegate.

The Committee has been informed that in practice, this procedure is rarely followed, and inmates are seldom removed from the program. There is a clear bias towards keeping people in the programs, creating difficult situations for nursing staff as inmates feel assured of their continuity on the program. The Committee was informed of attempts by nursing staff to enforce the rules only to be overruled by medical staff.

(c) Lack of Counselling

National Guidelines provide that methadone treatment, whether for maintenance or detoxification, should be provided in conjunction with social, psychological and medical services. The decision to place inmates on programs should involve consideration of advice from counselling and non-custodial staff. Counselling to inmates on methadone was provided by Drug and Alcohol Workers when the program was under the control of DOCS. Following the transfer to the PMS however, little if any counselling is provided to inmates. Several inmates complained about this lack of counselling in responses to surveys. This is particularly significant for inmates directed by the court to obtain counselling. One inmate who was pregnant was advised to increase her dose of methadone but was unable to discuss this with any counsellor.
"I am 4 months pregnant and on the methadone program. It has been suggested to me that I go up on my methadone. I hold certain fears as to this in regard to my child's and my well being. The problem that exists is there is no one I can discuss these fears with" (letter from inmate).

The lack of counselling has resulted in stress to inmates and nurses, and antagonism between the PMS and Drug and Alcohol Workers.

As the program aims to encourage a drug-free lifestyle, the lack of counselling seems to the Committee to be a serious omission. Counselling plays an important role in an effective methadone program.

(d) Security Problems

DOCS staff have expressed concern about the difficulties in operating a Methadone Program. These include the problem of inmates standing over other inmates, the need to provide facilities and staff to supervise inmates following the receipt of their Methadone, and the classification and placement limitations on inmates.

From the point of view of the PMS, a significant amount of nursing time is consumed by the administration of methadone.

Another security issue which has come to the Committee's attention relates to the transport of methadone samples. The Committee has been informed of instances where nurses have been required to collect bulk doses of methadone from local pharmacies, and then transport them back to the gaols with no security escort.

20.10 Conclusion

The Prison Methadone Program raises a number of complex issues. The Committee was therefore concerned to consult with a wide range of people with experience and expertise in the field. This included staff of the Directorate of the Drug Offensive in the Department of Health, Drug and Alcohol workers in the gaol system, staff of the AIDS Bureau and independent medical experts working in the HIV/IV Drug use area. These people strongly believed that given the extent of risk-taking behaviour in gaols, the Prison Methadone Program had the potential to play an important role in the prevention of HIV/AIDS.

This view is shared by international experts. In 1987, a meeting of the World Health Organisation recommended that all strategies found to be effective in the prevention of HIV infection within the community should, wherever possible be implemented. Intravenous Drug Use and HIV/AIDS drug treatment regimes should be available in prisons to all dependent intravenous drug users. This would include all effective types of treatment for illicit opiate use, including methadone programs and withdrawal programs using medical, non medical and methadone detoxification.
DODO staff commented

"to preclude the use of methadone maintenance in prison, when it is demonstrated to be an effective treatment, would be irrational. The NSW Government is pioneering a program which may well be taken up in other jurisdictions, both nationally and internationally".

The Committee believes that it is crucial for the program to be administered in accordance with National Guidelines, and that for the essential components of the program, as outlined by DODO, to be present. If the program only amounts to dispensing methadone syrup, it ceases to be useful.

The Committee's view is that there are problems with the program as currently administered. However, given the known risks in gaol the Prison Methadone Program should continue on a provisional basis. On the basis that prisoners should have access to health care options and programs available to others in the community, the Committee believes that the Prison Methadone Program option should be available to prisoners who meet the appropriate criteria.

The Committee is aware that there are many staff within the prison system who do not understand the rationale for the program or who are not convinced of its benefits. Those who are aware of its benefits are understandably concerned by aspects of its current operation. The Committee believes that distribution of the paper prepared by DODO will assist in clarifying these issues.

The Committee is also aware that costs are incurred by DOCS in having the program within the gaol system. Currently these costs are absorbed by DOCS, but the Committee believes it is appropriate for funding to be sought from NCADA to defray these expenses.

DODO recommended that a Prison Methadone Program Management Committee be established, to meet 3 to 6 times annually. It is suggested that membership of this Committee consist of representatives of the Prison Medical Service, the Directorate of the Drug Offensive and the Methadone Sub-Committee. (The Methadone Sub-Committee is a Sub-Committee of the Medical Committee established under the Poisons Act. It makes recommendations to the Director-General of Health in relation to approvals to prescribe methadone). The PMS Review Committee supports this recommendation.

RECOMMENDATIONS

48. That the Prison Methadone Program continue, subject to a favourable evaluation by DOCS and DODO.

49. That national guidelines relating to the administration of the Prison Methadone Program be strictly adhered to. Assessment, monitoring and dispensing procedures should be in accordance with strict medical practice.
50. That the paper prepared for the Committee by DODO be widely distributed to relevant people in DOCS, PMS and other agencies.

51. That a Prison Methadone Program Management Committee be established, consisting of representatives of the Prison Medical Service, DOCS, the Methadone Sub-Committee and DODO.

FOOTNOTES

(1) Directorate of the Drug Offensive, Policies and Procedures for the Methadone Treatment of Opioid Dependence in NSW.

(2) PMS Policy Manual.


(4) ibid, p13.

(5) PMS Policy Manual.

CHAPTER 21

21.0 RECEPTION, ASSESSMENT AND HEALTH SCREENING OF PRISONERS

21.1 Need for Adequate Reception Procedures

In 1975, Mr Justice Nagle commented

"A most important aspect of medical services is examination and assessment on reception. This is important for custodial reasons as well as for the welfare of the prisoner. Unfortunately, on many occasions the medical examination on reception has been perfunctory and inadequate. Indeed, in some cases no examination has been conducted at all. There is no reason why this situation should not be remedied immediately". *(1)*

The prison population is generally accepted to be a group at high risk of illness, disease and self-injury. It is particularly important that prisoners facing such risks are identified during the reception process, as they are particularly vulnerable during the period immediately after initial reception. *(2)*

One of the most important roles played by the PMS is therefore in providing a medical, psychiatric and dental assessment of each inmate on reception to the prison system. This provides the opportunity for structured interviews to achieve comprehensive assessment, appropriate referral and the initiation of medication and treatment.

The role of an effective reception process in the prevention of suicide is well documented. A number of suicide prevention schemes have been developed in other jurisdictions, and specific preventive measures have been instituted in response to indicators of suicide risk. For instance, in New York State there is a highly successful Forensic Suicide Prevention Program, designed to facilitate the identification and treatment of prisoners who are suicidal or acutely mentally ill. The program involves close interagency cooperation and is based on a thorough screening form and intensive training of officers.

In the report of the Royal Commission into Aboriginal Deaths in Custody Mr Justice Muirhead also referred to the importance of the identification of persons "at risk":

"Police and prison officers have the responsibility of ensuring the safety of persons in their custody and they require some skills to identify persons in distress or at risk of death through illness, injury or suicide... Police and prison officers, if properly trained, can do much to minimise custodial deaths. All officers should receive basic training so that from the time a person is apprehended or admitted to custody, warning signs that a prisoner may be distressed or at risk will not go unnoticed. Suspicion that all is not well must result in urgent medical referral". *(3)*
21.2 Procedure in NSW

Clause 11 of the Prisons (Administration) Regulation provides that the medical officer of a prison "is to cause each prisoner to be examined as soon after reception as is practicable" and then, "as required by this part or the Director-General, to cause to be carried out such medical examinations, investigations and treatment of such prisoners as may be reasonably necessary." Records of the results of such examination investigation or treatment must be made immediately by the medical officer.

In NSW, nursing staff generally have total responsibility for the assessment process. Medical staff are only called on where necessary, generally through referral to Doctor's "sick parade" when next available. The assessment process is generally short, and revolves around the completion of a reception form (Appendix G) which collects only limited information.

In her review of NSW PMS nursing services, Ms Closs commented that given the poor physical and mental health of many offenders and the number of prisoners with drug and alcohol addiction problems, the initial examination should be the responsibility of a medical officer. She also commented that the reception process is stressful and time consuming for nurses, and that consideration should be given to providing a multi-disciplinary reception process either at the Long Bay Complex or through a team in each region with a nurse experienced in psychiatric care included in each team.

The Committee believes that a well developed screening process will ensure that the most disadvantaged prisoners (for example, those with an intellectual disability) are not put "at risk" in the gaol population.

The present medical reception form (Appendix G) includes several questions which aim to identify people with an intellectual disability. The Committee believes that more appropriately worded questions may yield more information, and that some form of functional (i.e. practical) assessment, in addition to verbal questions may be necessary in the reception screening process.

The Committee believes that all prisoners should receive a prison life orientation counselling program from a staff member on entry to gaol. This program should be conducted by staff who are able to communicate clearly with prisoners with specific needs.

21.3 Procedure in Victoria

In mid 1988, in Victoria, a thorough reception process was established, based at "F" Division of Pentridge gaol. The program was jointly initiated and funded by the Health Department, Victoria and the Office of Corrections through the interim Corrections Health Board. Prior to initiation of this process, there was an average of 6 or 7 suicides each year, and there were 11 in the previous 18 months. Over the last two and half years, there have been none. The Committee believes that this is a most
impressive result and that the program could offer considerable benefits in NSW.

All new prisoners received into the prison from the police and courts are interviewed: up to 60 new prisoners per week undergo health assessment on the day of their reception to gaol. Assessment includes completion of a health questionnaire filled out by the prisoner or a Prison Medical Support Officer. (Prison Medical Support Officers are prison officers employed by the Office of Corrections who have received some medical training and who have a significant role in relation to the Victorian Prison Medical Service). Following this a medical practitioner takes a further medical history and conducts a physical examination. Particular effort is made to review previous illnesses, particularly where they may influence present health or future assessment within the prison system, and to assess and treat ongoing medical conditions.

Included in the process of reception is the screening of prisoners for Hepatitis B, Syphilis and HIV. Although the procedure is voluntary, 99% of new receptions have been prepared to undergo blood testing.

At the end of the assessment, prisoners are given access to a telephone to inform relatives of their incarceration. After this process referrals may be made to a psychiatric nurse, psychologist, Aboriginal Welfare Service or "B" Annex (a special purpose unit designed to accommodate vulnerable prisoners).

Some categories of prisoners are typically referred on to other professionals, including:
  - young prisoners
  - sex offenders
  - first time prisoners
  - psychiatrically disturbed prisoners
  - prisoners who are despondent or potentially suicidal, distressed or overly anxious
  - prisoners who are physically or intellectually disabled
  - prisoners withdrawing from drugs or alcohol
  - Aboriginal and Torres Strait Islander prisoners.

A prisoner displaying a serious psychiatric disorder is assessed by a nurse and referred to a prison psychiatrist. Less serious matters are dealt with by placing the prisoner on "standard observation" with a follow-up interview being conducted within one or two days.

A report conducted by the Victorian Corrections Health Board concluded:

"In practice, prisoners are very carefully screened by Reception Officers and their particular needs dealt with promptly by the medical and psychiatric staff on duty during the assessment process. Astute observation skills combined with a knowledge of prisoners' history and good communication between staff provide a system of prisoner reception which is very proactive".\(^{(4)}\)
21.4 Transfer of information

Effective assessment of prisoners is dependent on appropriate co-operation between the police, DOCS and the PMS. It is important that relevant information concerning prisoner health care is communicated between agencies.

Where prisoners are received from police custody, they are accompanied by a prisoner admission form which stays with the prisoner during transport and is intended to facilitate continuity of care. A Police Custody Manual contains guidelines and advice for police for dealing with persons in custody.

In May 1990, following inquests held in April and May 1990, Mr J.W. Hiatt, the Coroner, informed the Minister for Corrective Services and the Minister for Health of his concern about the lack of adequate communication between the Prison Medical Service and Custodial Services. He referred to the apparent breakdown in communication between services in drawing attention to prisoners who are a risk to themselves or who have suicidal tendencies. The breakdown, he said, had been related to a belief that medical services information could not be disclosed because of patient-doctor confidentiality.

"In the court’s opinion, if the computer record has information which gives a warning that a prisoner was previously on protection, then it could also have provision for information giving a warning that the prisoner was previously assessed as being a risk to himself. It is my opinion that such a procedure would not breach the confidentiality provisions, however, even if it did (which the court doubts) it is my opinion that such a breach would be clearly outweighed by the public interest that such prisoners ought to be properly and safely incarcerated".

The Royal Commission into Aboriginal Deaths in Custody similarly recognised that there was a balance to be struck between confidentiality on one hand, and the proper care and protection of the individual prisoner on the other. It commented that there are obvious cases where the information is of vital importance to the care of the prisoner. It said that it is absolutely essential that these matters be resolved between corrections and medical staff.

"It is not only important that some agreement be reached as to the type of information which should be divulged, but also as regards the categories of persons to whom, and the circumstances in which, such information should be divulged, and any other appropriate safeguards".

The Royal Commission into Aboriginal Deaths in Custody recommended that protocols be established for the transfer between police and DOCS of information about the physical or mental condition of Aboriginal persons which may create or increase the risk of deaths or injury to people when in custody. Safeguards were recommended to protect the privacy and confidentiality of prisoners to the extent that this is compatible with adequate care.
The Committee is aware that the Prison Medical Service and DOCS are jointly considering a system whereby the PMS can obtain access to DOCS computer files. This will allow DOCS staff access to medical record numbers and PMS staff access to a "self-harm" index. This index will contain information about prisoners' previous attempts at self-harm in gaol. If there were entries on this index in respect of any prisoner, nursing staff would be expected to view relevant medical documents.

The Committee acknowledges that information about prisoners' previous gaol history is an indicator of risk of subsequent harm, and supports moves which will allow such risks to be identified. However, there are limitations in this system since other factors have been shown to be relevant to risk, for example, being a first time offender and being sentenced for a major crime. It is important that such factors are identified as part of a comprehensive screening program. This is discussed in more detail in Chapter 19.

The Committee supports such moves as are necessary to allow the Royal Commission's recommendations to be implemented. It believes that the initiatives of the PMS are worthwhile, but that there are limitations on the current system. It believes that it should be further developed in conjunction with people who have psychiatric expertise.

21.5 Need for Data Collection

The Committee found that little data about inmates' health is collected on a routine level. Information is generally collected on a Reception form, (Appendix G) but the content of this form is minimal. Collection of comprehensive information is important and consistent with good medical practice, providing knowledge of relevant facts, including background and medical history. Such information also aids planning and evaluation of services.

In addition, effective research is not possible without the collection of detailed information about prisoner health. There is a marked lack of epidemiological information about prisoners' health in Australia. (See Chapter 4). De-identified data from initial assessment could provide the basis for research on patterns of health need in prisoners.

At the First National Corrections Health Conference in 1991, Professor Richard Harding referred to the need for an Australia-wide health survey of prisoners. Such a study will assist in ensuring that health care needs of NSW prisoners are met.

In the Committee's view, a data base should be established for the collection of ongoing statistics concerning utilisation of health services, and the health status of inmates.

It is also desirable to collect information about recent significant stress suffered by inmates (apart from as a result of incarceration) and to gather a minimum history about the prisoner's social support in the community.
This data should include a thorough medical history for each inmate, including, where applicable, the following factors: previous hospitalisation; abuse of drugs and alcohol; previous mental illness; evidence of intellectual disability; behaviour disorders; sexually transmitted diseases; HIV/AIDS status; infectious diseases including hepatitis and tuberculosis; skin infections and diseases; trauma; abnormalities of teeth and mouth, including dental hygiene; visual and auditory deficits; liver dysfunction; genitourinary problems; hypertension; obstetric-gynaecological problems; epilepsy; allergies; coronary heart disease; and previous self-mutilation and suicide attempts. It is also important to collect information about recent significant stress suffered by inmates, (apart from as a result of incarceration) and to gather a minimum history about the prisoner’s social support in the community.

The data base should also collect information regarding medical care utilisation, medication taken and health promotion programs. In addition, on-going research programs of benefit to the prison population on special problems of target groups, should be part of the role of the PMS alone or in conjunction with outside researchers. An example would be research on stress, overcrowding and physical symptomatology.

Obviously there are privacy considerations to be taken into account in the collection of such sensitive information. It is most important that due consideration be given to issues of confidentiality. It is understood that the NSW Privacy Committee provides advice and assistance on matters such as this.

RECOMMENDATIONS

52. That a comprehensive multi-disciplinary screening process be instituted for all prisoners received into custody.

53. That protocols be established for the transfer between police, DOCS and the PMS of information about the physical or mental condition of prisoners which may create or increase the risk of death or injury while in custody.

54. That safeguards be established to protect the privacy and confidentiality of health-related information about prisoners to the extent that is compatible with adequate care.

55. That relevant government organisations (DOCS, FACS, PMS, and the Department of Education) and the community groups (e.g. the NSW Council on Intellectual Disability and Australian Society for the Study of Intellectual Disability) work to develop appropriate screening indicators for intellectual disability.

56. That an adequate data base be established containing information about the health status of prisoners and the utilisation of health services.
57. That the Board review the data collection and records system for the PMS with a view to devising a functionally efficient system adapted to both planning and clinical needs.

FOOTNOTES

(1) Royal Commission into NSW Prisons, p516.


(3) Interim Report, p45.

(4) Victorian Corrections Health Board, Reception Assessment - Review of Prisoner Referrals.
22.0 MEDICAL RECORDS

The PMS holds a large amount of information in its record system, much of which relates to the health of individual prisoners. The existence of this information raises questions about its collection, storage, use and dissemination, and about who has access to it. The sensitivity of the information demands that it be treated confidentially, taking into account privacy considerations. On the other hand, it is crucial that information is made available to those who have a legitimate need for it. (See Chapter 21, Reception Assessment and Health Screening of Prisoners).

The PMS is currently proceeding to computerise its medical records system and has recently received a grant of $23,000 towards this. In the computerised system, all medical records will be optically scanned and placed on laser disc when a prisoner is released. It is envisaged that the information will be able to be accessed by all gaols as it is developed.

The PMS and DOCS are also jointly designing a system whereby the PMS can obtain access to the DOCS computer files. This allows staff access to medical record numbers and to a "self harm" index. This is discussed further in Chapter 21.

The Director of the PMS has also advised the Committee that the appointment of a medical records administrator has increased the efficiency of the system.

22.1 Storage

Medical records are currently held in a fairly standard medical record folder, filed in a terminal digit system. The main storage area is in the prison hospital. Medical records for female prisoners are held in the clinic area. Gaols which are "remote from" Long Bay retain relevant medical records there.

The PMS report that there are problems with storage of records and is attempting to address this problem.

22.2 Access to Prisoners' records

The Director of the PMS states that prisoners have "the usual" access to their own medical records. Following a written request by the prisoner, the prisoner is given access to the file under the supervision of nursing staff. The Director advises that access by others to prisoners' records is "restricted to PMS staff with one or two minor exceptions". These minor exceptions include prison psychologists, occupational therapists, and physiotherapists. Regulations under the Prisons Act require information to be given to DOCS staff in some circumstances.

22.3 Security

The medical records section is closed down at night and the key is held by the
Assistant Director of Nursing on duty.

During transport of prisoners between gaols, files are put in locked satchels which are given to escorting officers and handed over to clinic staff on arrival at the receiving gaol. The Director of the PMS believes that the procedure for transfer of files with prisoners between gaols has become much more efficient over the last few months.

22.4 Problems with Record System

Prisoners have complained to the Committee that they often consult doctors who do not have their records available.

Career Medical Officers at the gaol agree that access to records can be difficult. For example prisoners have arrived at the reception gaol, to find that their medical records are unavailable. Nurses either have to go and get them, or prisoners are rescheduled for the next day when their records can be obtained. This is obviously an inefficient procedure.

There is also limited access to records by staff at country gaols. The Committee believes that access to records is very important for prisoners' health and the lack of access-and delayed access to medical information can have serious consequences.

The Privacy Committee was established to deal with issues such as those discussed above, and has expertise in balancing privacy interests against other competing interests.

RECOMMENDATIONS

58. That the computerisation of medical records be further developed, having regard to privacy safeguards.

59. That the Privacy Committee be consulted where appropriate in relation to the record and information system of the PMS.
23.0 ROLE OF THE PRISON MEDICAL SERVICE IN PREVENTIVE HEALTH CARE

Preventive health care has a particular significance in the inherently unhealthy environment of a gaol. Factors such as diet, exercise, stress management and effective health screening are particularly important in preventive health care.

The extent to which such measures are implemented has the capacity to greatly affect the PMS. At the most significant level, effective screening and referral may prevent suicides - at least they allow recognition of existing conditions and appropriate intervention, facilitating better outcomes for patients and overall cost savings.

There are however a number of problems which militate against the provision of preventive health schemes in gaols, not the least of which is the unique position of the PMS in facilities controlled by the DOCS, and the different perspectives of the DOCS and the DOH. For example, the former Minister for Corrective Services recently introduced a policy, which, for "security" reasons drastically reduced the amount of property available to prisoners. The implementation of this policy meant that among items confiscated were prisoners' hats, thongs and sunglasses. As a result, many prisoners working outside in the hot summer sun had no protection from the sun's rays. Ironically, this occurred as the Department of Health launched a high-profile campaign ("Me-No-Fry") aimed at creating general awareness of the dangers of overexposure to the sun, and urging "common sense" preventive measures (such as wearing hats and using sunscreens). The Committee understands that there has been some relaxation of this property policy in relation to hats, following representations by the Director of the Prison Medical Service. In a similar vein, the prohibition of prisoners owning thongs has directly increased their chances of contracting tinea in communal showers. The Committee understands that prisoners can apply for thongs on health grounds if they develop tinea. This is clearly unsatisfactory.

The issue of HIV/AIDS is an area in which preventive measures are particularly important. For some time, the Department of Health and the Ministerial Committee on AIDS strategy have supported a policy which will allow prisoners access to bleach, clean injecting equipment (needles) and condoms in a bid to reduce the transmission of AIDS through use of unclean needles or sexual transmission.

The DOCS has consistently rejected these proposals. Prison officers' industrial bodies have also opposed the introduction of condoms. In 1989 the Premier intervened and directed that Milton tablets (which dissolve in water to form a bleach solution) be made available to prisoners through the PMS.

Health education, in relation to promoting such issues as nutrition, exercise, stress management, and drug and alcohol awareness can also contribute significantly to improving the health status of NSW prisoners.
In the final report of the Royal Commission into Aboriginal Deaths in Custody, Justice Johnstone referred to the focus on curative, rather than educational and promotional health care in prison health services. He commented:

"It is my impression that little is provided in the way of preventative health care programs to prison inmates ... there has been a shift in the general community towards preventative and promotional health care. If the standard of prison health care is to truly reflect that available in the general community, it is essential that prison health services be adequately resourced to provide a service which encompasses preventive health care programs"(1)

The Committee agree with these views. Consistent with the policy of equal health care treatment for prisoners, preventive policies should be implemented within gaols unless there are compelling reasons to the contrary.

RECOMMENDATION

60. That where the Department of Health has an existing preventive care policy, this should be implemented as far as possible in the gaol system.

FOOTNOTE

CHAPTER 24

24.0 QUALITY ASSURANCE

Quality Assurance is a term used to describe all evaluation activities being conducted in a service. The Australian Council on Healthcare Standards (ACHS) defines quality assurance as "a planned, systematic approach to monitoring and assessing the care provided, or the service being provided, that identifies opportunities for improvement and provides a mechanism through which action is taken to make and maintain these improvements". The "quality assurance cycle" consists of monitoring, assessment, evaluation, follow-up, and feedback. Quality Assurance can consist of both clinical and non-clinical review, and can apply across a wide range of health care and other services.

Across the health care system generally, quality assurance is being seen as complementing accountability and leading to an improved quality of service. One writer in the area states:

"without clinical review, both hospital and medical staff are open to charges that their approach to the quality of care offered is cavalier or outdated"[1]

In the Prison Medical Service, there is no formal peer review system or any formal method of evaluating clinical decisions. The Director of the PMS has advised the Committee

"While I accept that this is a theoretical nicety, because of the disparate nature of the organisation, the mobility of the client group and the number of people involved, there is a "de facto" evaluation system, in that each Doctor gets to see what each other Doctor does ... I would be interested to receive any suggestions as to how a more formalised system could be practically introduced".

The Committee acknowledges difficulties in ensuring effective quality assurance in the prison system, but believes that it is a most important concept for all services and staff. The Committee believes that the proposed new management structure will assist in ensuring the operation of Quality Assurance.

RECOMMENDATIONS

61. That Quality Assurance be applied to all services, including management services, provided by the PMS.

62. That the statement of duties for those clinically responsible in the new structure include the development of Quality Assurance strategies for the Prison Medical Service.
63. That staff be fully involved in the gradual introduction of Quality Assurance as standard organisational practice.

64. That steps be taken to investigate appropriate outcome criteria for health care services delivered in custodial settings.

FOOTNOTE

CHAPTER 25

25.0 ROLE OF THE COMMONWEALTH

25.1 Custodial Role

There is no separate Federal prison in Australia for holding prisoners convicted of offences against the Commonwealth, and there is no prison for convicted offenders in the Australian Capital Territory. Federal offenders sentenced to imprisonment have been confined in State criminal justice institutions since Federation under s.120 of the Australian Constitution. Prisoners sentenced in the ACT are held in NSW prisons. The Federal Attorney-General’s Department maintains a register of ACT prisoners and the NSW Department of Corrective Services is reimbursed for the costs of maintaining them according to an established formula.

25.2 Health Role

Although the Commonwealth makes a substantial contribution to health costs of the general community (through payment of Medicare benefits) these benefits are not available to prisoners or to the institutions in which they are detained. The Committee has been informed that under section 19(2) of the Health Insurance Act prisoners lose their entitlement to Medicare benefits, on the basis that they are the responsibility of the State as opposed to the Commonwealth. This appears to apply to remand prisoners as well as sentenced prisoners, despite the fact that remand prisoners are legally innocent of any offence.

The Committee is aware that, on the same basis, there is some doubt about whether prisoners subject to periodic detention are entitled to medicare benefits, even for the period in which they are not detained. The Minister for Community Services and Health may, on application, deem certain persons to be eligible or ineligible for Medicare benefits. This issue is currently being investigated by DOCS.

RECOMMENDATION

65. That, in negotiations with the Commonwealth, the Minister consider the issue of the availability of Medicare benefits to prisoners on remand and prisoners subject to Periodic Detention.
26.0 COMPLAINTS BY PRISONERS

The PMS has an established procedure for receiving complaints from prisoners. If a complaint is received in writing, the person in charge of the area from where the complaint arose is asked by the Director to respond. Other complaints are sent to the Nursing Unit Manager of the gaol for advice. A formal response will generally be made if complaints originate from the Complaints Unit of the Department of Health or the Ombudsman's Office. The Director of the PMS makes a determination and final response on any complaint.

In the course of this review of the PMS, a number of serious allegations have been made about medical care provided to prisoners by the PMS. Some allegations were made directly to the Committee, in submissions and surveys. Others were reported in the media, particularly during recent gaol riots. The Committee was not in a position to fully investigate these allegations, and has not attempted to do so.

The Committee believes that all prisoners should be fully informed of their right to make complaints to relevant authorities. Where complaints concern medical services provided by the PMS, the Complaints Unit will generally be the most appropriate body to investigate them. In 1989, it received seven complaints about the PMS from prisoners, one from the Ombudsman and one from an Official Visitor. Complaints related to psychiatric care, alleged lack of treatment, poor attitude of staff and inappropriate level of treatment.

Apart from the Complaints Unit, complaints about the Prison Medical Service may also be made by prisoners to:

- the Superintendent of the gaol
- Official Visitors
- the Minister for Health Services Management
- the Minister for Corrective Services
- the NSW Ombudsman

However many prisoners are not aware that they have the right to complain about medical services provided by the PMS. The Committee believes that it is most important that prisoners are aware of these rights, and that prisoners should also be able to make complaints about medical services to the Board.

RECOMMENDATIONS

66. That prisoners be formally advised on reception to gaol of their right to make complaints about the Prison Medical Service, and given information about the Complaints Unit and other avenues of complaint.

67. That information about complaints procedures be in a form appropriate for people of low literacy skills, and people whose first language is not English.
27.0 OUTSTANDING ISSUES

A number of other matters which require inter-departmental co-operation have come to the attention of the Committee. The Committee was not fully able to investigate the issues raised, but believes that it is appropriate for the Board to address them. They include:

- access to medical records by PMS and DOCS staff (see Chapter 21)
- transport of methadone without escorts (see Chapter 20)
- use, administration and effectiveness of medical holds
- delays in referral to Doctors
- policy on safe observation of disturbed prisoners
- transfers between hospitals and gaols
CHAPTER 28

28.0 VIEWS ABOUT THE PMS

28.1 Nurses' views

The Committee distributed fifty copies of surveys to PMS nurses, and the Director of Nursing distributed some further copies, for which the Committee is grateful. Thirty-three completed responses were received, some from nurses who had worked for the PMS for only a matter of months, others from nurses who had worked there for over ten years. Listed below are some of the questions asked by the Committee, and some responses received.

What initially attracted you to working for the PMS?

- A challenge; stable employment; to gain experience.

What are the main difficulties facing nurses in the PMS?

- Very high turnover in staff means I might be the only person on a shift who knows what to do. Shortage of staff means PMS can't be choosy about who they employ, it's difficult when you frequently work with people who are incompetent, lazy or just uninterested. Also this means that when casual staff pick and choose their shifts, PMS has no choice but to let them, simply in order to fill the shifts somehow. This irritates the full-time staff who feel that they are badly treated.

- Constant interference with the nursing role and management by one Director of the PMS. The Nursing Dept should be managed by the Director of Nursing. Lack of funding which leads to the cutting of staffing levels. This often leads to nursing staff feeling as though they have to compromise their professionalism.

- Lack of nursing staff, we are chronically short-staffed. Some staff have "attitude" problems, and do not pull their weight, they are quite happy to bludge.

- Isolation, ignorance, lack of support from Supervisors.


- Lack of staff. Verbal abuse by inmates, being locked in an area for long periods of time, very unacceptable environmental allowance 50 cents/hr. Possible physical abuse by inmates. Nursing minimum levels are very low, too low.
"Crossing over" (to prison nursing) from nursing the general public (in a somewhat more relaxed setting) and becoming familiar with the need to uphold the strict security rules.

What are the advantages of working for the PMS?

- Challenging environment, nothing's constant or boring. Working with the inmates. Concept that you can help where others have given up. Respect of the prisoners that you will help if you can. I find the inmates, male and female a demanding people but I know at times that I have had some input into helping them have a more positive outlook to their lives. Working for the public service. Promotional aspects of Nursing Division.

- Continual education - always something new to deal with. Confidence improved as have my skills e.g. nursing diagnosis, examination techniques, psychiatric/counselling skills. Familiarity with pharmaceutical goods, new drugs and psychiatric drugs. Nurses becoming real health practitioners.

- Challenging work. Good money.

- Friendly staff, you get to know everyone. A good relationship with nursing administration. Clinical work is fun and a good change from hospital work. You build a good relationship with everyone associated with care of inmates e.g. doctors, psychiatrists, social workers etc. due to small numbers.

- Close knit staff who are very supportive and understanding of your day to day work and the situations which you may find yourself in.

What are the disadvantages of working for the PMS?

- The public perception of gaol nurses as being shoddy. Being uncertain about the future, being constantly told that we must cut back even further. Having important information about PMS matters (for example, plans to reopen a ward) kept from staff for no apparent reason. Being unable to be sincere when assuring patients that doctors know what they are doing, having to listen to inmates boast about manipulating doctors. Having to spend a lot of time justifying therapeutic behaviour, in the face of criticism by ignorant prison officers.

- Isolated from other health agencies. Not being in charge of the ward due to some Corrective Services staff's unwillingness to accept that nurses are responsible and autonomous. In the clinics, not having enough nurses or not having enough officers, so not able to see enough patients.

- The lack of coverage by psychiatrists. Nursing staff are expected to manage patients on the acute admission ward for up to a week at a time before they can be seen again. Responsible for ordering phone dosages of medication from medical officers without anyone having been seen.
Our identity to outside health services seems to be undesirable. Our client population are very difficult to trust. Terrible clinical facilities.

The poor public hospital perception of the abilities of PMS staff. Lack of inservice education. Poor medical administration understanding of the Nurse's function.

Not enough staff, especially registered nurses. Because it is hard to recruit or retain staff too many enrolled nurses are employed just to make up numbers. Workload increasing all the time. Extra duties and responsibilities, no reward given, less staff, no monetary increase.

You miss the nurse-patient contact you are accustomed to in a General Hospital.

**What do you enjoy most about working for the PMS?**

- Individual prison clinics - have "great team" who are very helpful.

**What do you enjoy least about working for the PMS?**

- Observing administration treat with complete disregard some of the finest nurses I have ever worked with. The lack of environmental needs for the emotionally disturbed clients. Restricted access to clients special needs, e.g. diabetic diets, hats for clients on Largactil. The lack of pharmaceutical lines for treatment etc. The sexist attitude of administration towards female nurses with children and rosters.

- The frustration of working for the Dept of Health rules, Dept of Corrective Services rules, community pressure, political environment. Defensive nursing, "in case you go to court", not enough time for health education and promotion.

- Increasing workload with increasing paperwork without a concurrent increase in benefits or inservice education.

- The frustration of not being able to do what you want exactly when you want to do it e.g., the doors are locked and an officer is unavailable to accompany you.

**How satisfactory was the training you received for this job?**

- Very unsatisfactory!! Only 3½ days orientation. I had never seen a prison before in my life!!

- My nursing training was sufficient and I started here so long ago we were all thrown in at the deep end. Can anything prepare you for Correctional Nursing?
How satisfactory is the level of back-up and support you receive from the PMS in your job?

Support is strong when it comes to nursing staff having made a decision that other disciplines do not agree with. The Director of Nursing supports his nursing staff fully. The same cannot be said of the Director of the PMS, whose attitude towards nurses is unprofessional and at times degrading.

I feel the medical staff back up is far from adequate. I feel that the Nursing admin support is better, but the "bottom line" (an often repeated phrase) is always that we don’t have enough money; or "you’ll just have to do your best".

Support very good.

How satisfactory is the level of back-up and support you receive from DOCS?

Physical protection is very good, but in order to be sure that it will stay that way one must be sure to stay on the right side of prison officers. This involves a lot of tactful answering when they question what a nurse is actually doing for and with an inmate whom they see as a "rat". There is also a strong element of male/female power dynamics; prison officers find it hard to see that a psychiatric nurse may be able to "talk down" a patient who is angry and threatening; they are quick to jump in and protect, sometimes in a physically inappropriately threatening way, in a situation which could be more therapeutically and tactfully handled. One must at all times walk a thin line between wanting protection against injury, and doing the right thing by a patient and his mental state.

On the whole reasonable. However a lot of pressure is put on me at times, especially working in the gaol clinics to provide staff of Corrective Services with sick notes, medications, dressings etc. I’m sure they feel we are employed as occupational nurses for their needs first, and the inmates are a long way second. Sometimes they subtly insinuate if I don’t look after them, they would not look after my safety.

In many ways DOCS is often more supportive. They acknowledge that we need more staff, more support etc.

Do you believe that prisoners receive the same level of medical care as that received by the rest of the community?

Long waiting lists to see specialists and for outside appointments - then sometimes transport can’t take patients due to lack of staff. Difficulty in contacting M.O.’s and then in getting them to do a proper job. Same true of psychiatrists at times.
In some cases yes, in others, no. Senior DOCS staff have the power, which disadvantages others in gaining care. Government policy - budgetary restrictions. Isolation of some prisoners. Inadequate services.

No - short staffed so not enough time to provide adequate assessment. Continual movement of prisoners through one system - no continuity of care. Chaotic system for referral of inmates to specialist facilities.

What specific difficulties apply to nursing in a prison setting?

The patients initial lack of trust, unwillingness to disclose what's going on in their lives, won't ask for Milton in case DOCS are told, suspicion that blood, urine samples will be tampered with. Inmates believe that when nurse informs of dispensing restrictions they are playing power games - mind you nurses have to overcome the difficulty of not turning into custodial officer nurses.

Unable to visit inmates in wings. Getting over barriers of distrust. Psychological problems arising from incarceration. Inability to take sick leave when needed due to no casual staff being available to replace staff.

Don't have access to inmates as desired. Inmates don't always tell the truth, they can be very manipulative. Personal stress as lack of staff. Burn out as too much overtime required to just get by with band aid care.

The obvious lack of patient/nurse rapport because of necessary security precautions. Having to be aware of possible danger at all times. Overcoming the problem of being "too familiar" with the patient whilst at the same time providing a caring yet professional approach.

Are there times when you believe there are conflicts between health and correctional aims in the PMS?

Yes. Emergency psych transfers are difficult to understand as there is no physical signs only mental so non-medical trained staff cannot understand the problem, i.e. suicide may be result.

Yes definitely!

Have you experienced any ethical difficulties in nursing in the PMS?

Yes one's licence is constantly under threat because of the number and types of decisions that have to be made i.e., Status.epileptics given IV drugs whilst waiting the forty-five minutes for the ambulance to arrive.

No, any situations which have arisen have been dealt with to my satisfaction through the appropriate channels. However, I can see that some situations may be difficult for inexperienced or non-assertive staff.
Sometimes but these have to be approached and let your conscience be your guide.

Do you believe there are adequate resources made available to the PMS?

- No, and the resources available are not used wisely.
- Hard to tell; I don't know whether the Director is in fact a very bad manager or whether there are insufficient resources.
- No - our equipment is antiquated or absent. We need equipment that will quicken our work practices, not slow us down as time is our greatest restriction.
- No. In some country areas specialists are not available, e.g. dental, medical, physio.
- No. Educational, financial, etc. resources are far from adequate.
- There might be on paper or in peoples mind but lack of staff and funds make this unrealistic.

Have you experienced any difficulties in dealing with staff of external health care agencies in the course of your work?

- Occasionally yes. "Oh oh a criminal" probably got Hep B/AIDS". Difficulty in getting appointments in the public system especially orthopaedic and dermatologist bookings.
- No, they have been very co-operative and interested to learn about our service.

In what way do you think the PMS might change in the next 2 years?

- It could only improve we hope but most probably will continue to limp along - prisoners are great survivors - the RN's not quite so. Only the fact that the public hospital system is worse keeps us here.

In what way do you think the PMS should change in the next 2 years?

- Equal opportunity for all nurses for a clear career path for those sincere and hard working nurses. No more favouritism, please. Better training and education for nurses. Better co-operation between the custodial and nursing staff. Better communication between all levels of staff.
- Medical Admin - especially the Director, should have less say in how things are run i.e., clinics, services provided etc. No member of the Nursing Staff was involved in writing the Nursing Policy manual - unbelievable isn't it!
Do you have any other general comments?

- Nurses self esteem often low through lack of support and counselling. Also through no clear definition of duties. Also nil in-service lectures.

- Nurses in the PMS are only hanging on. They need help and encouragement that things will get better. They can only see things getting worse. Someone soon will have to help.
28.2 Superintendent's Views

The PMS Review Committee sent out surveys to Superintendents of all gaols, and received 23 responses. The following lists the areas about which questions were asked, and the responses of Superintendents to those questions. Not all questions were answered by all respondents.

Standard of Service Provided by PMS

Superintendents were asked to rate the service provided by the PMS. Responses were:

- Excellent 2
- Good 8
- Reasonable 6
- Poor 6

Access by Prisoners to Medical Care

Superintendents were asked to rate access by prisoners to medical care. Responses were:

- Excellent 4
- Good 9
- Reasonable 1
- Poor 9

A number of Superintendents referred to what they saw as unreasonable delays and waiting times for services, and commented on how recent cuts and financial constraints had affected prisoner access. Many said that access was fine when staff were available, but referred to problems of access out of hours, at weekends and on public holidays. Others referred to the disparity between country and city gaols. For example, the comment was made:

"The level of health care in isolated institutions can only be described as disgraceful and places an intolerable strain on the nursing staff who work in them."

HIV Infection

Superintendents were asked whether HIV infection created any particular medical problems at their gaols. Responses were:

- No 15
- Yes 2

They were also asked whether it was the role of the gaol to be involved in the treatment and prevention of HIV infection in gaols. 16 answered yes, with the
comment being made by one person:

"All of us have a responsibility to maximise the treatment and health of those at risk".

On this issue a number of comments favoured increased and continued AIDS education programs, and several raised the issue of access by Superintendents and officers to results of HIV tests, generally favouring increased access.

Drug and Alcohol Addiction

Similar questions were asked in relation to Drug and Alcohol addiction, as had been asked about HIV infection.

10 Superintendents believed that D&A addiction created special problems in the gaol, 9 did not.

One Superintendent commented that there were

"(No problems) specifically, other than the sheer numbers of drug/alcohol affected inmates, particularly those under 25 years of age".

There was strong support for involvement of gaol staff in the treatment and prevention of drug and alcohol induced problems. 17 said that it was an appropriate role for the gaol,

"basically, because treatment of drug and alcohol problems is undoubtedly an effective and durable means of preventing prisoner recidivism".

15 Superintendents said that further steps could be taken within gaols in relation to this problem, for example:

"Ideally it would be appropriate to have another full-time drug and alcohol worker position, to enable more clients to access the service in terms of individual counselling and groupwork".

Expansion of Services and Programs

Superintendents were asked whether there were any medical services or programs they would like to see expanded. Responses were

Yes  13
No   5

Several comments related to the need for more staff, to reduce delays for medical and dental treatment. This was seen to be particularly applicable to nursing hours. Other specific examples of programs seen to be necessary included the availability of a woman doctor and family planning services in women's gaols. Again, references were
made to what was perceived to be a lack of services in country institutions.

One comment made by a Superintendent of a country institution was:

"before expansion I would like to see proper health care extended to all prisoners in all locations, not just the big ones close to Sydney".

**Comparison with the Community**

Superintendents were asked whether they believed prisoners received the same level of medical care as that received by the rest of the community. 13 answered that they believed it was, and some in fact commented that it was probably better than in most public situations.

"Prisoners at this centre receive a high level of nursing and medical care including specialist and dental services".

A number however made the point that prisoners are unable to have their choice of medical practitioner, and frequently had to rely on escorts, which are subject to cancellation. Others remarked that in the general community, there are no delays in medical or dental treatment, but in gaol

"if the Doctor does not come or you are too far down the list you can wait for weeks".

Others commented that financial constraints limited the availability of medical care provided. One comment was:

"Whilst the care given by the sister when she is on duty is of the very highest standard, the restrictions placed on her attendance at the institution are such that, if applied to the general community, it would be totally unacceptable and would cause an outcry".

**Role and Existence of PMS**

Superintendents were asked whether the role or existence of the PMS created any special difficulties for Corrective Services officers. Opinion on this issue was fairly evenly divided, with 10 Superintendents answering yes and 9 no.

Many comments were quite positive, stating for instance:

"Co-operation between both Departments has always been of a high standard".

Others referred to issues which are discussed in other sections of this report. They included:

"Lack of direct control by DOCS"
"Even as administrator of the institution I have no control/say over the medical attention/treatment of inmates. But when it comes to emergency cases it always falls back on the custodial staff to rectify the situation".

Special Needs for Medical Services

Superintendents were asked whether they had special needs for medical services at their institutions. 14 said they did, and 13 said that these special needs were not being met. Many referred to the need for increased psychiatric or psychological services.

"observation for inmates with specific problems (severe behavioural, psychiatric and drug withdrawal) is not satisfactory".

"urgent need... for part-time psychologist and drug and alcohol (worker)".

"full-time psychiatric assessment (is necessary)"

Others referred to the need for more hours for health care staff and for methadone assessment.

Relationship Between PMS and DOCS

Superintendents were asked for comments on the relation between the PMS and DOCS.

Opinions on this issue ranged from

"excellent in smaller gaols, where effort is made on both parts. Insufficient forums available for unstressed communication."

to

"there is a conflict relationship between the PMS and Corrective Services. It appears that the PMS has withdrawn medical services ... without prior consultation or consideration as to the repercussions caused to the inmates".
28.3 Inmates’ Views

The Committee felt that just as it is desirable to obtain the views of consumers of health care services in evaluating services in the outside community, it was desirable to obtain the views of inmates in reviewing the PMS. As part of its research, the Committee decided to survey a sample of inmates. It requested that copies of surveys be distributed by Superintendents to a cross section of inmates. The completed surveys were then collected by the Superintendents and returned to the Committee. The exercise proved very successful, and the Committee received a total of 274 completed surveys from 23 different institutions. The Committee is grateful for the co-operation of DOCS. Although the Committee accepts that the survey results are not scientifically accurate, they are nonetheless still interesting.

The Committee was most impressed by the standard of responses from inmates. Many had taken a good deal of time and trouble to complete the surveys, and there were some very thoughtful and considered views expressed. There was a wide variation in prisoners’ views on each question. Although many inmates had critical comments, they also generally attempted to give credit where it was due.

Some were sceptical about the survey and the review, but others appreciated having been asked for their contribution. The Committee believes that prisoners raised important issues and made some useful suggestions, and has drawn on them in other sections of the report.

Listed below are the questions inmates were asked and their collated responses.

Extracts from the surveys, reflecting the diversity of inmates’ views, are also reproduced below.

Do you have any health problems?
Yes 56%
No 44%

Since you have been inside, have you been to see a:-
Nurse
Yes 92%
No 8%

If yes, were you happy with the service you got there?
Yes 69%
No 31%

Doctor
Yes 83%
No 17%
If yes, were you happy with the service you got there?
Yes 49%
No 51%

Dentist
Yes 62%
No 38%

If yes, were you happy with the service you got there?
Yes 49%
No 51%

Psychiatrist
Yes 41%
No 59%

If yes, were you happy with the service you got there?
Yes 63%
No 37%

Other Specialist
Yes 39%
No 61%

If yes, were you happy with the service you got there?
Yes 75%
No 25%

Do you think the medical care you get in gaol is the same as people get outside?
Yes 20%
No 80%

Do you think there are ways in which the Prison Medical Service could be improved?
Yes 81%
No 13%

Do you have any other comments about this review?

Comments

I feel because we are in prison we are discriminated (against) and treated as second class human beings. Even though we have done wrong by the community, I think a person’s health should be treated very carefully and not taken so lightly. Therefore, regardless of where we are, we should be treated and diagnosed as we would if we were seeking medical advice outside.

The nursing staff overall (not all) think everytime that we as prisoners are
trying to sort something out of them. But in the most part prisoners only go to the clinic when they are in need of medication because it is such a hassle to get treated properly.

No you are treated to two Panadol for all complaints.

Every nurse has been helpful, sympathetic, understanding to my problems.

My psychiatrist has given me the most help in my life, excellent.

Have been given 4 different dates to see the orthopaedic specialist, and have not been seen on any occasions at all.

It's outrageous and most unprofessional, to say the least. Even on remand (supposedly not guilty) we are treated as though we have no rights to medical treatment, and I have personally been told I don't deserve medical treatment, as I am nothing but a criminal, and know of quite a few other inmates who have experienced the same.

I feel that with a little bit more dedication from medical staff, and more patience from inmates, a lot of the problems could be solved. I understand that some of the medical staff get fed up with the stories that are told to them, but not all inmates are habitual liars, and therefore, each case should be considered on its individual merits, and not on pre-conceived ideas of some staff.

Numerous changes could be implemented, namely, more staff to service the needs of the inmates, better facilities for the staff to service the needs of those who are chronically ill. Proper assessment of new arrivals, and ascertain their mental as well as physical condition. If a person has severe mental disorders, he should be placed in the appropriate section (D Ward or B Ward) not in general population, for this not only compounds his or her problems, it can often lead to physical abuse from some inmates, which I feel is totally inhumane. Also, if prisoners could be checked upon arrival for any easily transmitted infections, lice, rabies, tinias etc., because of late, we have had a severe outbreak of the above, and I for one came in with no transmissible diseases, and I don't want to leave with any.

I feel that understaffing is the main reason things aren't up to scratch. This not only makes it hard for inmates, but staff are put under great pressure as well. The welfare of staff should be greatly considered. In many instances they are abused, sometimes violently, thus making their attitude negative. This is mainly due to lack of facilities and lack of staff.

I feel frustrated at not having any realistic avenue of complaint, as I'm sure, do many inmates.

I think the nursing staff are on a whole very responsible, competent
professional people. They are not responsible for the poor conditions they have to endure during their working days.

I have had occasion to have assessment by Department Psychologists and found these people very helpful and I feel more emphasis should be placed on analysis and treatment in this system.

The visiting doctor or nurse should come more often.

Some inmates genuinely need medication for certain medical conditions, but the prison medical staff will not give medication, especially in larger gaols. You know when you talk to them that they don't believe you.

Have been in custody 8½ months and have yet to get teeth fixed due to lack of staff.

Stress causes a lot of trouble and nothing is done to relieve stress.

I have found most nurses in the prisons have been helpful and knowledgeable. However when on "strict protection" at Long Bay it can be very difficult to contact the nurse.

I have seen 3 different psychiatrists/psychologists and they have all been most understanding and helpful.

I feel access to the doctor should be improved. It would appear that many inmates have difficulty seeing the doctor. There are also many inmates who require dental treatment and it appears that only the most urgent cases are treated and then usually by extracting the tooth.

Overall the service is good but at times it is hard to convince nurses that what you are saying is true. Most nurses are very good.

We appear to have in our prison a fully set up dental clinic. I have not seen it used in the 8 months I have been here. One would think it would be cost saving to have a visiting dentist rather than send inmates under escort to an outside surgery.

Another point that should also be looked into is the availability of and access to medical staff by prisoners not well and also the instalments of emergency first aid kits including respirators and what ever else is necessary for emergency in all of the industries in every gaol. In some gaols if an inmate or even an officer for that matter has a serious accident it can take up to half an hour to transfer the injured person to the clinics or a nurse or doctor to get to the work place. I would also like to see more first aid courses available in the gaols to any prisoner that wishes to take part. I also feel that compulsory first aid training should be undertaken by all prison officers regardless of rank as well.
Visits to the Gaol by the doctor are limited and to expedite the flow of patients, consultations are hurried, diagnosis and treatments are not discussed with the prisoner. To determine one's illness and medication if necessary, requires another visit to the clinic some hours later when the nurse briefly relates to one the possible diagnosis and the intended treatment. There is no doctor-patient relationship at all.

Out of hours availability or at least a nurse is a worry to most inmates, particularly the ill and older ones. The clinic is only accessible from 0700 - approximately 1400 - Monday to Friday, 0800 to 11.30 weekends public holiday and R.D.O's.

Prison Officers, although they do their best are not trained to cope with or handle medical emergencies which occur regularly in all gaols and institutions. A delay of even five minutes in obtaining the on-call nurse could prove fatal.

Regular review of inmates medical condition and medications may reduce or eliminate over medication.

I am a medical practitioner and the service provided here is as poor as any I have ever-known.

I feel that it isn't the psychiatrists fault, but the inmates, that they get unnecessary drugs. It is hard to determine whether they are anti-depressed or depressed at times.

Most of the time the nursing staff have been great with me - I'm not a junkie or fake illnesses so that makes a big different as to the way I'm treated, also I'm respectful to the medical staff.

We would like to have a nurse on 24-hours-a-day plus a doctor few times a week plus we would like to see more of the psychiatrist please.

It appears that doctors, dentists, etc., who visit prisons are time limited, therefore they are not able to relate to the patient enabling them to discover any (if any) underlying problems.

The medical staff in this gaol is very good, but I feel the time they have to spend with drug addiction prisoners takes up to 99% of their time, and I feel that prisoners with the usual medical ailments sometimes are being neglected because of the drug problem. This is only the feeling I get myself personally, may be I expect too much, I can only speak for myself.

Have had my name down since the end of November to see a gynaecologist, have repeatedly asked to see one, and still haven't.

Too many complaints are put down as tension and nerves and no tests are done to get to the cause of a problem.
Too few specialists are brought in and when they are, the time they are here is too short. The gynaecologist comes once every 2 weeks for 3 hours. For a women's prison this seems totally inadequate to me, as she also sees the other gaols in the complex. More transport should be provided for escorts outside.

I'm only a prisoner, I don't think it would matter if I was to complain as we have no rights.

Although personally satisfied, my needs have been simple, but I have been witness to the problems of others with more complex needs and the nurses seem to be restricted by staff shortages, lack of finances and political "buck-passing", as well as communication break-downs with their higher-ups.

I do feel that some counsellors are needed for people early in their sentences. They have drug and alcohol people but no one for just basic counselling. The only thing that stopped me having a nervous break-down was the fact that my ex-wife was a psychologist and I had learnt a little from her.

I think that the gaol Superintendent should be given more authority regarding medical decisions made because he is in personal contact with the prisoner involved and therefore able to make a reasonable physiological profile of the prisoner and with the medical advise he receives from the doctor, is in the best position to make a quick and accurate assessment of the situation, therefore eliminating a lot of time consuming red-tape as well as any malingering.

The nurses are very understanding about my situation and they listen and show a lot of concern.

The dentist was concerned about how nervous I was to see him, he was very understanding and reassured me that everything would be o.k. which settled me a lot.

All prisons are overcrowded (don't have enough Prison Staff). If remission was brought back in there would be some relief of the overcrowding. Hepatitis B vaccination should be given upon entry to prison (instead of 3 months later and only for convicted prisoners) because conditions like overcrowding exacerbate cockroach problems, and disease transmission.
APPENDIX A - SUBMISSIONS RECEIVED

The following lists individuals and organisations who provided written information to the Committee.

- Aboriginal Medical Service Co-operative Ltd.
- AIDS Action Committee, Grafton Gaol.
- AIDS Bureau, Department of Health.
- AIDS Council of NSW.
- Mr John Basten.
- Ms Zoe de Crestigny, Co-ordinator, Prison AIDS Project, Western Country Gaols.
- Dr Les Darcy, Allandale Nursing Homes and Community Services.
- Dr Geo Gluckstern, Acting Director, Psychiatric Services, P.M.S.
- Dr Angela Gorta, Chief Research Officer, Research and Statistics Division, Department of Corrective Services.
- Mr Angus Graham, Director-General, D.O.C.S.
- Associate Professor Susan Hayes, Department of Behavioural Science in Medicine, University of Sydney.
- Ms. June Heinrich, Principal, Corrective Services Academy.
- Mr Stephen Kerr, Manager, Corrections Health Services, Health Department of Victoria.
- The Hon. Elizabeth Kirkby, M.L.C., State Parliamentary Leader, NSW, Australian Democrats.
- Legal Aid Commission of NSW.
- Dr Christopher Liew, Director, Prison Medical Service, S.A.
- NSW Prisons Coalition.
- Mr E.R. Nixon, Deputy Director-General, D.O.C.S.
- Prison Superintendents.
Ms Alison Pattinson, Assistant Director, Programmes Division, D.O.C.S.

- Prison Medical Service Staff.

- Dr Bryan Todd, Director of Health and Medical Services, Queensland Corrective Services Commission.

- Ms Merrilyn Walton, Director, Complaints Unit, NSW Department of Health.

- Mr J. Weston.

- Ms Julie Williams, Nursing Branch, NSW Department of Health.
APPENDIX B - MEETINGS HELD

The PMS Review Committee held meetings with the following people:-

- Dr Frank McLeod, Director, PMS.
- Dr Pooba Govender, Deputy Director, PMS.
- Mr John Carmody, Director of Nursing, PMS.
- Executive staff, Nursing, PMS.
- Executive staff, Department of Corrective Services.
- Dr Robert Weidenhofer, Chief Dental Officer, Department of Health.
- Staff of the Directorate of the Drug Offensive, Department of Health.
- Staff of the Programs Directorate, Department of Corrective Services.
- Staff of the AIDS Bureau, Department of Health.
- Senior psychologists, Department of Corrective Services.
- Staff of the Corrections Health Board, Victoria.
- Ms Judith Meppem, Chief Nursing Officer, Department of Health.
- Career MedicalOfficers.
- Finance Officers, Department of Health.
- Mr Richard Gilbert, Department of Health.
APPENDIX C - UNITED NATIONS - STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS

22.(1) At every institution there shall be available the services of at least one qualified medical officer, who should have some knowledge of psychiatry. The medical services should be organised in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.

(2) Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishing and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a suitably trained officers.

23.(1) In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment.

24. The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

25.(1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

(2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be seriously affected by continued imprisonment or by any condition of imprisonment.

61. The treatment or prisoners should emphasise not their exclusion from the community, but their continuing part of it. Community agencies should, therefore, be enlisted wherever possible to assist the staff of the institution in the task of social rehabilitation of the prisoners. There should be in connection with every institution social workers charged with the duty of maintaining and improving all desirable relations of a prisoner with his family and with valuable social agencies. Steps should be taken to safeguard, to the maximum extent compatible with the law and the sentence, the rights relating to civil interests, social security rights and other social benefits of prisoners.
82.(1) Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to move them to mental institutions as soon as possible.

(2) Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in special institutions under medical management.

(3) During their stay in prison, such prisoners shall be placed under the special supervision of a medical officer.

(4) The medical or psychiatric service of the penal institution shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.
APPENDIX D - GAOLS SERVED BY THE PMS

The following lists operational gaols, and their approximate populations, as at early 1991.

- Metropolitan

Long Bay Correctional Centre comprises 5 gaols, and the Prison Hospital is located within the complex. The five gaols are:

<table>
<thead>
<tr>
<th>Gaol</th>
<th>Population</th>
<th>Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remand Centre (2)*</td>
<td>356</td>
<td>Maximum</td>
</tr>
<tr>
<td>Special Purpose Prison</td>
<td>62</td>
<td>Maximum</td>
</tr>
<tr>
<td>Assessment Prison (6)</td>
<td>345</td>
<td>Maximum</td>
</tr>
<tr>
<td>Reception Prison (3)</td>
<td>592</td>
<td>Maximum</td>
</tr>
<tr>
<td>Training Centre</td>
<td>281</td>
<td>Minimum</td>
</tr>
</tbody>
</table>

*Figures in brackets indicate the number of management areas - e.g., the Reception Prison is divided into General Discipline, Five Wing (Strict Protection) and One Wing (Protection and Strict Protection).

- Western Metropolitan Area

<table>
<thead>
<tr>
<th>Gaol</th>
<th>Population</th>
<th>Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mulawa (7)</td>
<td>284</td>
<td>Various</td>
</tr>
<tr>
<td>Silverwater</td>
<td>290</td>
<td>Minimum</td>
</tr>
<tr>
<td>Parramatta (2)</td>
<td>484</td>
<td>Medium</td>
</tr>
<tr>
<td>Parklea (3)</td>
<td>300</td>
<td>Maximum</td>
</tr>
<tr>
<td>Emu Plains</td>
<td>142</td>
<td>-</td>
</tr>
<tr>
<td>Norma Parker</td>
<td>60</td>
<td>Minimum</td>
</tr>
</tbody>
</table>

- Country - West

<table>
<thead>
<tr>
<th>Gaol</th>
<th>Population</th>
<th>Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathurst (2)</td>
<td>400</td>
<td>Medium</td>
</tr>
<tr>
<td>Broken Hill</td>
<td>20</td>
<td>-</td>
</tr>
<tr>
<td>Oberon Camp</td>
<td>95</td>
<td>Minimum</td>
</tr>
<tr>
<td>Kirkonnell Camp</td>
<td>82</td>
<td>Minimum</td>
</tr>
<tr>
<td>Lithgow</td>
<td></td>
<td>Maximum</td>
</tr>
</tbody>
</table>

- Country - North

<table>
<thead>
<tr>
<th>Gaol</th>
<th>Population</th>
<th>Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grafton (2)</td>
<td>214</td>
<td>Various</td>
</tr>
<tr>
<td>Glen Innes Camp</td>
<td>140</td>
<td>Minimum</td>
</tr>
<tr>
<td>St. Hellier’s, Muswellbrook</td>
<td>160</td>
<td>Minimum</td>
</tr>
<tr>
<td>Maitland (3)</td>
<td>180</td>
<td>Maximum</td>
</tr>
<tr>
<td>Cessnock</td>
<td>396</td>
<td>-</td>
</tr>
</tbody>
</table>

- Country - South

<table>
<thead>
<tr>
<th>Gaol</th>
<th>Population</th>
<th>Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berrima</td>
<td>57</td>
<td>Medium &amp; Min.</td>
</tr>
<tr>
<td>Goulburn (5)</td>
<td>540</td>
<td>Various</td>
</tr>
<tr>
<td>Cooma</td>
<td>158</td>
<td>Medium</td>
</tr>
<tr>
<td>Brookfield Camp, Mannus</td>
<td>114</td>
<td>Minimum</td>
</tr>
</tbody>
</table>
PERIODIC DETENTION CENTRES

Long Bay
Tomago
Silverwater
Parramatta
Emu Plains
Windsor
Campbelltown
Meninda (Parramatta)
Muswellbrook

All Minimum
APPENDIX E - RECOMMENDATIONS OF ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY - FINAL REPORT, MAY 1991

130. That:

a. Protocols be established for the transfer between Police and Corrective Services of information about the physical or mental condition of an Aboriginal person which may create or increase the risks of death or injury to that person when in custody;

b. In developing such protocols, Police Services, Corrective Services and health authorities with Aboriginal Legal Services and Aboriginal Health Services should establish procedures for the transfer of such information and establish necessary safe-guards to protect the rights of privacy and confidentiality of individual prisoners to the extent compatible with adequate care; and

c. Such protocols should be subject to relevant ministerial approval.

150. That the health care available to persons in correctional institutions should be of an equivalent standard to that available to the general public. Services provided to inmates of correctional institutions should include medical, dental, mental health, drug and alcohol services provided either within the correctional institutions or made available by ready access to community facilities and services. Health services provided within correctional institutions should be adequately resourced and be staffed by appropriately qualified and competent personnel. Such services should be both accessible and appropriate to Aboriginal prisoners. Correctional institutions should provide 24 hour a day access to medical practitioners and nursing staff who are either available on the premises, or on call.

151. That, wherever possible, Aboriginal prisoners or detainees requiring psychiatric assessment or treatment should be referred to a psychiatrist with knowledge and experience of Aboriginal persons. The Commission recognises that there are limited numbers of psychiatrists with such experience. The Commission notes that, in many instances, medical practitioners who are or have been employed by Aboriginal Health Services are not specialists in psychiatry, but have experience and knowledge which would benefit inmates requiring psychiatric assessment or care.

152. That Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon, the following matters together with other matters thought appropriate:

a. The standard of general and mental health care available to Aboriginal prisoners in each correctional institution;

b. The extent to which services provided are culturally appropriate for and are used by Aboriginal inmates. Particular attention should be given to drug and
alcohol treatment, rehabilitative and preventative education and counselling programs for Aboriginal prisoners. Such programs should be provided, where possible, by Aboriginal people;

c. The involvement of Aboriginal Health Services in the provision of general and mental health care to Aboriginal prisoners;

d. The development of appropriate facilities for the behaviourally disturbed;

e. The exchange of relevant information between prison medical staff and external health and medical agencies, including Aboriginal Health Services, as to risk factors in the detention of any Aboriginal inmate, and as to the protection of the rights of privacy and confidentiality of such inmates so far as is consistent with their proper care;

f. The establishment of detailed guidelines governing the exchange of information between prison medical staff, corrections officers and corrections administrators with respect to the health and safety of prisoners. Such guidelines must recognise both the rights of prisoners to confidentiality and privacy and the responsibilities of corrections officers for the informed care of prisoners. Such guidelines must also be public and be available to prisoners; and

g. The development of protocols detailing the specific action to be taken by officers with respect to the care and management of:

i. persons identified at the screening assessment on reception as being at risk or requiring any special consideration for whatever reason;

ii. intoxicated or drug affected persons, or persons with drug or alcohol related conditions;

iii. persons who are known to suffer from any serious illnesses or conditions such as epilepsy, diabetes or heart disease;

iv. persons who have made any attempt to harm themselves or who exhibit, or are believed to have exhibited, a tendency to violent, irrational or potentially self-injurious behaviour;

v. apparently angry, aggressive or disturbed persons;

vi. persons suffering from mental illness;

vii. other serious medical conditions;

viii. persons on medication; and

ix. such other persons or situations as agreed.
153. That:

a. Prison Medical Services should be the subject of ongoing review in the light of experiences in all jurisdictions;

b. The issue of confidentiality between prison medical staff and prisoners should be addressed by the relevant bodies, including prisoner groups; and

c. Whatever administrative model for the delivery of prison medical services is adopted, it is essential that medical staff should be responsible to professional medical officers rather than to prison administrators.

154. That:

a. All staff of Prison Medical Services should receive training to ensure that they have an understanding and appreciation of those issues which relate to Aboriginal health, including Aboriginal history, culture and life-style so as to assist them in their dealings with Aboriginal people;

b. Prison Medical Services consult with Aboriginal Health Services as to the information and training which would be appropriate for staff of Prison Medical Services in their dealings with Aboriginal people; and

c. Those agencies responsible for the delivery of health services in correctional institutions should endeavour to employ Aboriginal persons in those services.

155. That recruitment and in-service training of prison officers should include information as to the general health status of Aboriginal people and be designed to alert such officers to the foreseeable risk of Aboriginal people in their care suffering from those illnesses and conditions endemic to the Aboriginal population. Officers should also be trained to better enable them to identify persons in distress or at risk of death or harm through illness, injury or self-harm. Such training should also include training in the specific action to be taken in relation to the matters which are to be the subject of protocols referred to in Recommendation 152 (g).

156. That upon initial reception at a prison all Aboriginal prisoners should be subject to a thorough medical assessment with a view to determining whether the prisoner is at risk of injury, illness or self-harm. Such assessment on initial reception should be provided, wherever possible, by a medical practitioner. Where this is not possible, it should be performed within 24 hours by a medical practitioner or trained nurse. Where such assessment is performed by a trained nurse rather than a medical practitioner then examination by a medical practitioner should be provided within 72 hours of reception or at such earlier time as is requested by the trained nurse who performed such earlier assessment, or by the prisoner. Where upon assessment by a medical practitioner, trained nurse or such other person as performs an assessment within 72 hours of prisoners’ reception it is believed that psychiatric assessment is required then the Prison Medical Service should ensure that the prisoner is examined by a psychiatrist at the earliest possible opportunity. In this case, the matters referred
to in Recommendation 151 should be taken into account.

157. That, as part of the assessment procedure outline in Recommendation 156, efforts must be made by the Prison Medical Service to obtain a comprehensive medical history for the prisoner including medical records from a previous occasion of imprisonment, and where necessary, prior treatment records from hospitals and health services. In order to facilitate this process, procedures should be established to ensure that a prisoner's medical history files accompany the prisoner on transfer to other institutions and upon re-admission and that negotiations are undertaken between prison medical, hospital and health services to establish guidelines for the transfer of such information.
PRISON METHADONE PROGRAM

A. BACKGROUND

1. Methadone Treatment

Brief history

The methadone treatment of opioid dependence was first introduced in New York in 1964. Subsequently, a pilot program was introduced in NSW in 1969. The NSW program developed to a point in 1976 when 600 patients were in treatment. Following this peak there was a contraction of the program due to a change in policy at Department level. In 1979 there were only 400 patients in treatment. From 1979 to 1985 the program further expanded to a point in early 1985 when there were 800 patients in treatment.

In 1985, the NSW Government was preparing for a significant expansion of the methadone treatment system following the recommendations of a report by Dr. James Rankin, the then Director of Drug and Alcohol Services in NSW. The commencement of the National Campaign Against Drug Abuse provided a further impetus. The program then expanded very rapidly reaching 3,500 at the end of 1987 and 4,500 at the end of 1989. At the end of March 1991, there were 5,688 patients receiving methadone treatment in NSW including those in prisons.

Rationale

Methadone treatment is a relatively attractive treatment for many users of illicit opioids. There is no discomfort associated with withdrawal from illicit opioids when on methadone treatment and the patient can remain in the community and maintain employment and social relationships. This is an important aspect of treatment effectiveness because the substitution of illicit opioids with the appropriate dose of methadone can immediately curtail illicit opioid use, drug injecting behaviour and other related behaviour.

Methadone treatment in the community setting is generally provided as a comprehensive treatment for opioid dependence. It consists of assessment, administration of methadone doses, casework and referral services, and basic medical services. Urine screening for drug use is also carried out. An important issue in methadone treatment is to initially interrupt the illicit drug using behaviour and then to maintain and increase the duration of this interruption.
A central aspect of methadone treatment is the constant daily contact with staff necessitated by this particular form of treatment. Even a reluctant patient can be accessed for the purpose of brief HIV education.

In the community, methadone programs seek to interrupt intensive use of illicit opioids. The person who presents for treatment generally will be injecting opioids an average of three times per day. The interruption of illicit opioid use may be absolute or partial. A patient who reduces their use of opioids to three times per week is seen to be benefiting from methadone treatment. Of course, it is hoped that cessation of opioid use will be achieved.

An important aspect of methadone treatment relates to the phenomenon of cross-tolerance. Methadone at sufficient doses partially blocks the effect of other opioids. Although this is not absolute, it is often sufficient to make the use of extraneous opioids very expensive for the patient.

**NSW Methadone Program**

(i) aims and objectives:

The aims and objectives of the NSW Methadone program are clearly delineated in the NSW Department of Health policy document "Policies and Procedures for the Methadone Treatment of Opioid Dependence in NSW".

The principle aim is to assist the opioid dependent persons improve their health and social functioning and alleviate the adverse social consequences of their drug use by reducing and eliminating their illicit opioid use. The objectives are expressed in terms of both patient objectives and social objectives.

(ii) current status

At the end of March 1991, there were 5,688 patients in NSW receiving methadone treatment through the public and the private sector. The public sector accounts for 2,539 or 45% of these.

68% of patients attend specialist clinics, 24% attend a community retail pharmacy and 9% receive treatment in prisons. It is expected that the program will continue to grow at a rate of approximately 5% per annum.

**B. EFFECTIVENESS OF METHADONE TREATMENT**

1. The effectiveness in reducing opioid use

The effectiveness of treatment for drug use is generally measured in its ability to reduce or cease drug use, criminal activity, unemployment, morbidity, mortality and other social problems. More recently, the reduction or cessation of drug injecting
behaviour has become a significant focus of treatment as a means of reducing HIV infection.

Methadone has been shown to be very effective in reducing the use of opioids in patients. Ball\(^4\) has shown a cessation of IV drug use in 90% of patients at one methadone clinic, with an average of 70% over 6 methadone clinics in eastern USA. Furthermore, Ball has demonstrated a linear relationship between time in methadone treatment and reduced rates of IV drug use over four years. Other favourable outcomes from methadone treatment, such as improved employment, reduction in criminal activity, increased social and family functioning and increased physical health, have been well established.\(^3\)

Many studies have shown the relationship between time in treatment for drug use and favourable outcomes. In particular, Simpson and Sells\(^5\) in their overview of the DARP research program, pointed to the increasingly favourable post-treatment outcomes with longer time in treatment. This relationship was linear between 90 days and two years; the analysis of longer periods was frustrated by inadequate data.

2. Effectiveness in preventing HIV

The effectiveness of methadone treatment in the prevention of the spread of HIV is not well researched and there are a number of methodological issues which make such research very complex. The effectiveness of methadone in the prevention of HIV concerns its ability to reduce the use of needles. Studies mentioned earlier indicate that it is possible to achieve a 90% reduction in the illicit use of opioids in methadone patients. Such a reduction will generally be accompanied by a similar reduction in the use of needles. Other studies have demonstrated the effectiveness of methadone in reducing the frequency of drug use, drug injection, injection using shared equipment, and persons allowing others to use their equipment. Evidence from the same study showed that reductions in HIV risk behaviour correspond with length of time in treatment.

Some studies have pointed to the lower rates of HIV infection in methadone patients compared to other injecting drug users. In particular, there is evidence that drug users in methadone treatment have lower rates of HIV infection than drug users in therapeutic communities, in prison (but not in treatment), and those not in treatment.

3. Lifestyle Factors

Methadone treatment is also effective in stabilising a range of lifestyle factors including employment, family functioning, residence and physical health. The result is that, for many patients, treatment allows for an improvement in quality of life.

A large number of evaluation studies in methadone treatment have reported improvements in social functioning and employment among patients. Involvement in treatment helps to reduce participation in criminal behaviour. Studies have
demonstrated that heroin users who are not in treatment commit offences up to eight times more frequently than do heroin users who are undergoing methadone treatment.10

In Australia, a number of evaluation studies report reduced residential mobility, improved physical health and enhanced employment stability in methadone patients.11

4. The components of effective methadone treatment

Effective methadone treatment should consist of:

- assessment
- dosing services
- counselling and/or casework
- HIV education/information strategies
- monitoring and review procedures
- quality assurance mechanisms

(i) assessment

The objective of an assessment is to establish that the patient is dependent on opioids or otherwise suitable for methadone treatment. Further factors which need to be considered include the patient’s general capacity and desire to undergo treatment. There are certain requisites of methadone treatment which the patient and the assessor need to consider carefully such as the ability of the patient to attend a clinic daily for a period of approximately two years, possibly longer. Many patients may not realise that a physical dependence to methadone develops in treatment and this can be a restricting factor in a person’s life over a number of years. It is a far more preferable dependence than the illicit one, however, a patient may need to assess whether he/she will be better served by another form of treatment. An assessment is well used to provide the potential patient with basic information about methadone treatment and to examine from an objective viewpoint his or her general suitability for the treatment.

(ii) dosing services

A methadone program should include, or have access to, consistent, reliable methadone dosing services. Take-away doses should be minimised to reduce the diversion of methadone and the potential for its misuse. Further, the daily attendance of the patient at a clinic or pharmacy is an opportunity to provide ongoing health education, prevention services and referral to other health of welfare services where required. The dosing services should provide methadone in a confidential atmosphere and in one where observation of the patient is sufficient to:

- identify the person presenting as the patient for whom the dose is prescribed,
- determine the patient’s level of consciousness prior to dosing and
to ensure the ingestion of the methadone dose by the patient. These services are generally staffed by registered nurses or pharmacists.

(iii) counselling and/or casework

Counselling and casework provide the patient with the opportunity to bring problems relating to their treatment directly to the attention of a clinician. This can have an effect in preventing relapse into illicit opioid use by a problem-solving approach, basic skills training and referral to other specialist services. Moreover, it provides a regular opportunity to monitor the patient.

(iv) HIV education/information

Methadone treatment necessitates, under normal circumstances, the daily contact between the patient and the health service. This is a valuable opportunity to provide appropriate information and education in HIV prevention strategies.

(v) monitoring and review procedures

Monitoring and review procedures are required to track the patient throughout treatment to provide regular checks to determine the patient's continuing suitability for the treatment regimen in place. These should include the services of counsellors or caseworkers, regular case conference and medical examination. Counsellors may provide valuable assistance to patients in terms of advice in specific problematic situations. However, regular contact between a caseworker and the patient can serve also to alert clinicians to circumstances which threaten the patient's progress or well-being. Medical examination includes urine drug screening and consultation with a medical practitioner. The latter is particularly important in the early stages of treatment to establish a suitable dose of methadone for the individual. The transition from illicit opioids to methadone in the early stages of treatment represents a potential danger to the patient.

(vi) quality assurance mechanisms

There should be mechanisms in place in methadone programs to ensure that basic standards are achieved in terms of operational processes and clinical treatment procedures. These may include the definition of procedures at a local level, clinical audits, case conferences, regular urine drug screening.

C. PRISON METHADONE PROGRAM

1. Background

Brief History

The Prison Methadone Program commenced in April, 1986 as a pilot program. Entry to treatment was voluntary and it operated as a pre-release program in 3
prisons: Mulawa, Bathurst and Parramatta. Prisoners were able to enter treatment provided they:
- had a history of opioid dependence;
- were at least 18 years old;
- had a history of drug related crime;
- were willing to change;
- had 12 to 16 weeks to release date.

In 1987/88 the Program was expanded to 11 prisons. Policy changes allowed for the further provision of treatment to prisoners:
- in methadone treatment at the time of imprisonment;
- serving long sentences;
- who were HIV+ or Hepatitis B infected.

The Program was administered by the Department of Corrective Services until June 1990, after which it was administered by the Department of Health through the Prison Medical Service. At the end of March 1991, there were 518 patients in methadone treatment within prisons in NSW.

Rationale

In prisons, the argument for providing methadone treatment continues to be its effectiveness in attracting people into treatment, interrupting their drug use and maintaining this interruption as much as possible. The need to interrupt drug use in prisons is not as great as in the community because the illicit use of opioids in prisons is generally not sustained due to irregular supplies. A regular user in prison may only be able to obtain enough heroin to use, say, three times per week. The interruption then becomes of a different order. For example, if it is possible to reduce that regularity to three times per month, then there is benefit in the treatment.

In prisons, the concentration of risk factors for the spread of HIV is of particular concern: the concentration of drug users (60% of male and 85-90% female prisoners have been convicted of drug-related crimes), homosexual sex and injecting behaviour in the absence of either condoms or sufficient supplies of clean needles and bleach. The small population in a prison increases the weight of each individual's risk factors in the risk equation. Therefore, there is a greater urgency to maximise reductions and achieve cessation of injecting behaviour. Methadone has an increased role in this regard in the absence of freely available injecting equipment in prisons.

It might be argued that cross-tolerance and its potential to block the effect of other opioids is particularly relevant in prison. Prisoners use drugs opportunistically as a way to allay boredom. This type of use, when it involves opioids, may be particularly susceptible to methadone dose manipulation by the prescriber. If methadone doses are sufficiently high, say 80 milligrams and over, the methadone patient who uses heroin in a prison would need to outlay a large amount of currency on a drug which has little effect. In a prison economy, this may be a
significant factor in preventing injecting drug use. If there is a low rate of HIV seropositivity and limited opioid use in gaols then these may be contained and limited even further by methadone treatment.

Counselling for prisoners undergoing methadone treatment may be of value in the situation where a prisoner is having difficulties in avoiding regular or occasional use of opioids. Skills may be imparted which assist the prisoner in preventing relapse in the prison setting. Moreover, personal problems which threaten the stability of the patient may be identified and treated before they contribute to relapse. Casework is valuable in the planning of treatment changes over time, identifying lapses in progress and putting into place strategies which will act against relapse.

As mentioned earlier, there are also benefits in methadone treatment to be gained from the sustained daily contact between prison medical service staff and patients in relation to HIV education and prevention strategies.

**Aims and Objectives**

The "Policies and Procedures for the Methadone Treatment of Opioid Dependence in NSW" details two main aims and five objectives of the Prison Methadone Program as follows:

**AIMS**

To reduce the harmful effects of the use of illicit opioids in NSW prisons and minimise the likelihood of relapse into illicit drug dependence following release.

**OBJECTIVES**

- to reduce the incidence of intravenous heroin use by prisoners;
- to reduce the spread of HIV and Hepatitis B amongst prisoners;
- to continue the methadone treatment of prisoners incarcerated whilst in treatment;
- to commence the methadone treatment of prisoners who are suitable for this treatment;
- to facilitate prisoners transfer of methadone treatment from PMP to community methadone programs.

The aims differ significantly from those of the mainstream community program. The principle aim of the community methadone program is to

"...assist the opioid dependent person improve their health and social functioning and alleviate the adverse social consequences of their drug use by reducing and eliminating their illicit opioid use."

As mentioned earlier, the objectives of the community program are expressed in terms of both patient objectives and social objectives.

The aims and objectives of the Prison Methadone Program have a more primary
focus on the minimisation of harm as a public health issue rather than as an individual well-being issue. Of course, it is difficult to separate the two absolutely. However, in the prison setting, methadone treatment should be guided by the principle of doing no harm to the patient in an effort to avoid the consequences of his or her actions for the community.

2. Current Status

The Prison Methadone Program is currently operating at its maximum capacity of 500 patients. Unmet demand for treatment is reported to be approximately 60 prisoners per month. The Program continues to extend its service to prisoners in treatment at the time of imprisonment, despite full capacity. HIV+ prisoners are given priority into immediate treatment.

The Program has five methadone prescribers and methadone is dispensed in 20 NSW corrective institutions. Prisoners in treatment are not eligible for placement in prison camps, and, although eligible for minimum security prisons, are not able to participate in Works Release programs. Prisoners held in remand are only eligible for treatment after being imprisoned for over 3 months.

It has been reported that prisoners undergoing methadone treatment have inadequate access to counselling and support services. Staff of the Program provide a counselling service where and when they are able to do so. This may not be available to all methadone patient prisoners on request. Drug and alcohol counsellors employed by the Department of Corrective Services have a general policy of not providing services to methadone patient prisoners. This is less strictly adhered to in country prisons.

Treatment progress is monitored by urinalysis. Urine samples are taken at a minimum of once monthly, and a maximum of thrice weekly. The Department of Corrective Services have an additional random urinalysis scheme, from which prisoners can be charged for offences where illicit substances are detected. The Prison Methadone Program maintains the confidentiality of urinalysis results.

3. Evaluation

Previous evaluations

The Department of Corrective Services has carried out a number of studies since the commencement of the pilot program in 1986. These are:

Study 1, Profile of those Assessed for the Pilot Pre-release Methadone Program;

Study 2, Views of inmates participating in the Pilot Pre-release Methadone Program;

Study 3, Report on the first 201 Methadone Assessments;
Study 4, Results of Gaol Urinalysis: January - June 1987;

Study 5, The Views of Key Personnel involved with the administration of the NSW Prison Methadone Program;

Study 6, Results of Community Urinalysis for Clients on the NSW Prison Methadone Program;

Study 7, The Effects of the Prison Methadone Program on Criminal Recidivism and Retention in Methadone Treatment;

Study 8, The Views of Recidivists Released after participating in the NSW Prison Methadone Program and the Problems they face in the Community.

Study 9, Inmates perception of the role of the NSW Methadone Program in preventing the spread of Human Immunodeficiency Virus.

The findings of these studies are interesting but inconclusive as to the effectiveness of the program in achieving objectives, as there are flaws in the design and methodology of each.

A Review of the Prison Methadone Program was undertaken in 1988 by a committee of review following criticisms of the program in Study 5. The committee found that, inter alia, "assessment, monitoring and dispensing procedures are being carried out in accordance with sound medical practice, and diversion of methadone is likely to be rare". This, however was in the context of the program being jointly managed by the Department of Corrective Services and the Prison Medical Service. Since June 1990, the program has been managed by the Prison Medical Service only and this has involved the elimination of the team within Corrective Services who were responsible for initial assessment and monitoring. This same team undertook some casework duties which may no longer be available.

Current studies

The Department of Corrective Services and the Directorate of the Drug Offensive are currently carrying out a study which will attempt to compare the program pre and post 30 June 1990. This should provide a basis for detailed review of the methadone program and develop some research questions for the new administration. The specific issues under investigation are the perceived aims of the program, the mechanics of methadone dispensing, the adequacy of treatment protocol and the management of prisoners in the context of the methadone program. This study should be capable of establishing any management problems which exist for the Department of Corrective Services.

The study is currently at the stage of data analysis and is due to be completed by August 1991.
Areas Requiring Evaluation

The extent of drug use in NSW prisons is a matter of contention that has direct relevance to the validity of the Prison Methadone Program. The operations of the Program over the past 5 years suggest that heroin use is not uncommon in prison. An appropriate evaluation design would take into account measures of the proportion of prisoners using drugs, types of drugs, frequency and methods of use. Baseline information could be used to compare the effects of involvement in methadone treatment.

The weight given to methadone treatment as an HIV prevention strategy indicates a need for an evaluation of the direct impact of treatment on the spread of HIV, and the frequency of HIV transmission risk behaviours, in terms of both drug use and sexual behaviour.

In addition, the long term effectiveness of methadone treatment indicates a need for the evaluation of the post-release progress of patients. Patient retention and recidivism following release would provide a measure of the appropriateness of the prison assessment/treatment process.

4: Issues of Concern Raised by the Committee

Drug use in prisons

Prison is an extremely difficult environment from which to gain accurate information on the incidence and prevalence of IV drug use due to the existence of sanctions. The measurement of the achievement of objectives, therefore, is impeded by the unreliability of self-report. Anecdotal evidence suggests that injecting drug use in prisons is common, although not as intensive as in the community.

It is arguable that sufficiently high doses of methadone will reduce the occurrence of illicit drug use in prisoners who are at risk of using regularly in the prison context, irrespective of the level of drug use in prisons. It is important that those who are treated with methadone in prison are those who are at risk of using illicit opioids. This can be determined by rigorous assessment processes and specific quantitative research.

It is acknowledged that placement on a methadone program is no guarantee that prisoners will not use other injected drugs, if they are available. However, by targeting the use of opioids with methadone, a significant reduction in the use of injecting equipment is attainable.

HIV seroprevalence in prisons

Evidence from European prisons indicate that the proportion of prisoners who are HIV+ is approximately 10%. Estimates for the proportion of injecting drug using prisoners who are HIV+ are as high as 60%\(^{13}\). There is compelling evidence of the speed with which HIV can spread in populations of imprisoned injecting drug
users. Lack of access to sterile injecting equipment and bleach, and the need for concealment of injecting behaviour, increases the likelihood of shared equipment without adequate sterilisation. Lack of access to condoms, in an environment in which anal sex is frequent, increases the likelihood of the growth of a pool of HIV infected prisoners. This, in turn, increases the possibility of the spread of HIV via unsafe drug use practices.

Preliminary data suggests that the rate of HIV infection in NSW prison is still low. Therefore, it is important that preventive measures are implemented now.

**Opioid withdrawal programs**

All treatment modalities which are demonstrated to be effective in reducing the use of opioids and the use of injecting equipment should be available in prisons. Programs of withdrawal from opioids should also be available in order to provide the most appropriate treatment to each individual.

**Assessment practices**

Assessment in prisons, as in the community, is necessary to assess suitability for methadone treatment. However, the criteria for suitability for treatment in prisons is different from that in the community. Section 8.8.5 of the "Policies and Procedures for the Methadone Treatment of Opioid Dependence in NSW" indicates that opioid dependence or an extensive history of opioid use may not be necessary conditions for initiating treatment in prisons. Rather, a prisoner's sharing of drug injecting equipment may be sufficient grounds for initiating treatment. Assessment in prisons then should measure the level of opioid dependence and the history of illicit opioid use, as well as whether the patient is sharing injecting equipment. It should also assess the ability of the patient to continue treatment throughout the patient's incarceration and into the community.

Prisoners should not be commenced on methadone treatment without a thorough assessment of their suitability as stated in the policy. The assessment process should not rely on self-reported information only. Collateral information should be obtained to confirm that which is claimed by potential patients.

**Lack of similar program in Australia and elsewhere**

In 1987, a meeting of the World Health Organisation recommended that all strategies found to be effective in the prevention of HIV infection within the community should, wherever possible, be implemented within prisons.

According to the recommendation of the Working Panel on Intravenous Drug Use and HIV/AIDS, drug treatment programs should be available in prisons to all dependent intravenous drug users. This would include all effective types of treatment for illicit opioid use, including methadone programs and withdrawal.
programs using medical, non-medical and methadone detoxification. To preclude the use of methadone maintenance in prison, when it is demonstrated to be an effective treatment, would be irrational. The NSW Government is pioneering a program which may well be taken up by other jurisdictions, both nationally and internationally.

The effect of methadone on recidivism

The effect of methadone on recidivism has not been properly assessed due to the many variables which confound the issue. It would be necessary, for instance, to control for dose variation, the history of criminality in each individual, the period of incarceration and social, economic and physical factors. Study 7, mentioned above, contained fundamental errors which make its findings not useful in this question.

D. RECOMMENDATIONS

The Directorate of the Drug Offensive is concerned that the policies and procedures of the Prison Methadone Program are adhered to and that program effectiveness is maximised. Quality Assurance programs should be implemented and would assist in ensuring that this occurs.

A Prison Methadone Program Management Committee should be established. The committee could meet, say, three to six times annually. Membership of the committee should consist of representatives of the Prison Medical Service, the Department of Corrective Services, the Methadone Sub-committee and the Directorate of the Drug Offensive.

The Prison Medical Service should ensure that all the components of methadone treatment, as described earlier, are available within prisons.

Directorate of the Drug Offensive
10 May 1991
NOTES


3. Reduced Criminality:
Reynold and Magro, 1976; Dole and Joseph, 1978; Dalton and Duncan, 1979; Maddux and Desmond, 1979; Soew et al., 1980; McLennan et al., 1981; Hunt et al., 1984; Senay, 1988.

Reduced unemployment:
Dole and Nyswander, 1966; Gearing, 1970 and 1972; Maddux and Bowden, 1972; Reynolds and Magro, 1976; Block et al., 1977.

Increased Social and family functioning:

Increased Physical Health:
Reynolds, 1975; Reynolds and Magro, 1976; Webster et al., 1977; Dalton and Duncan, 1979; McGlothlin and Anglin, 1981; Swensen, 1983; Powell et al., 1984; Reilly et al., 1987.

Reduced mortality:
Gearing, 1970 and 72; Watterson, 1973; Gunn and Gronbladh, 1981.

Containing the spread of HIV:


   Swensen, G. A Descriptive Study of 227 Individuals Who Participated in a Western Australian Methadone Programme Over a 12-month Period, Western Australian Health Department, 1983.


<table>
<thead>
<tr>
<th>NEXT OF KIN:</th>
<th>SURNAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
<td>GIVEN NAMES:</td>
</tr>
<tr>
<td>TELEPHONE:</td>
<td>ALIASES:</td>
</tr>
<tr>
<td>INTERPRETER NEEDED:</td>
<td>DATE:</td>
</tr>
<tr>
<td>YES/NO</td>
<td>TIME:</td>
</tr>
<tr>
<td>LANGUAGE SPOKEN:</td>
<td>GAOL:</td>
</tr>
<tr>
<td>RELIGION:</td>
<td>GAOL No.</td>
</tr>
<tr>
<td></td>
<td>D.O.B.:</td>
</tr>
<tr>
<td></td>
<td>SEX:</td>
</tr>
<tr>
<td></td>
<td>HAVE YOU BEEN IN GAOL BEFORE?: YES/NO.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IN N.S.W.? YES/NO.</td>
</tr>
</tbody>
</table>

**MEDICAL HISTORY:**

- **MEDICAL/SURGICAL:**

  - **PSYCHIATRIC:**

  - **GYNAECOLOGICAL:**

  - **LAST PAP. SMEAR:**

  - **L.M.P.:**

  - **COULD YOU BE PREGNANT:**

  - **No. OF CHILDREN:**

  - **HEARING LOSS: YES/NO:**

  - **VISUAL IMPAIRMENT: YES/NO:**

  - **KNOWN ALLERGIES (RECORD IN RED):**

  - **CURRENT MEDICATION:**

  - **DEVELOPMENTAL DISABILITY: YES/NO**

  - **HAVE YOU EVER BEEN ON AN INVALID PENSION?: YES/NO:**

  - **DID YOU GO TO ONE/TWO OR "LOTS" OF SCHOOLS?:**

  - **HAVE YOU EVER BEEN IN A SPECIAL CLASS?:**

  - **DID YOU OFTEN "WAG" SCHOOL?: YES/NO:**

  - **WHY?:**
DRUG MISUSE

TYPE:.............................................
AGE WHEN FIRST USED:..........................
AMOUNT:............................................
METHOD OF INGESTION:...........................
LAST USED:........................................
PREVIOUS WITHDRAWALS:.........................

METHADONE PROGRAMME: YES/NO (If YES, Nurse Required to Complete Complete Separate Form).

ALCOHOL MISUSE

TYPE:.............................................
AMOUNT:.............................................
LAST USED:........................................
PREVIOUS WITHDRAWALS:

PULSE:...........................................
B.P.:................................................
WEIGHT:...........................................
HEIGHT:............................................

SUICIDE RISK

1. MURDER CHARGE OR SERIOUS ASSAULT YES/NO
2. ETHNIC ORIGIN FROM NON-ENGLISH SPEAKING BACKGROUND YES/NO
3. PREVIOUS PSYCHIATRIC HISTORY YES/NO

If any of the above factors are present, then the client should be specifically asked: ARE YOU FEELING SUICIDAL?

If the nurse is unsure following the reply to this last question, the Medical Officer should make a decision.

FOLLOW-UP PLAN:

..........................................
..........................................
..........................................
..........................................
..........................................
..........................................
..........................................

SIGNED:...........................................
BIBLIOGRAPHY


Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice, No. 13. Aboriginal Criminal Justice
No. 14. Adults under supervision and detention orders
No. 18. Alcohol and Crime
No. 19. Life Imprisonment in Australia
No. 21. AIDS and Prisons
No. 27. Remand Imprisonment in Australia


Battersby, D., Hemmings, L., Kermode S., Sutherland S., Cox J., NSW College of Nursing, Factors Influencing the Turnover and Retention of Registered Nurses in NSW Hospitals, March 1990.


Brown T, School of Nursing and Health Administration Mitchell College of Advanced Education, Correctional Health Nursing Books One and Two.

Bynoe I, "Lost in the System", Legal Action July 1990

Cawte J., Division of Health Services Planning, Eastern Sydney Area Health Service, Submission to Royal Commission Into Aboriginal Deaths in Custody, Fourth World Suicide and Stress, Contrasting Reactions in North America and Australia, July 1990.


Department of Corrective Services, Information for Women in Prison Task Force, "Profiling Study: Drug use, prior experience of rehabilitation, programmes and current treatment", 1984

Department of Corrective Services, Information for Women in Prison Task Force, Profiling System: Counselling Services

Department of Corrective Services, Research Publication No.19, The Effects of the NSW Prison Methadone Program on Criminal Recidivism and Retention in Methadone Treatment, 1989.


Grant C., Australian Hospitals - Operation and Management, 2nd edn, Melbourne.


Hayes S and Carmody J, Managing Mentally Abnormal Prisoners 1989 World Congress for Mental Health

Hayes S and Carmody J, Helping those imprisoned for Alcohol-related Crimes, Australian Institute of Criminology, Seminar on Alcohol and Crime Perth 4 - 6th April 1989

Health Department of NSW, Prison Medical Service Nursing Admin., *Correctional Health Nursing Guidelines for Clinical Nurse Specialist Classification*

Health Department Victoria, Office of Corrections, Health Programs in Victoria Prisons.


Inter-Departmental Committee on Aboriginal Deaths in Custody, *Review of Police and Department of Corrective Services Custodial Procedures*.


McLeod F.J., Carmody J., Report to the Director-General of Family and Community Services on Health Services to Juvenile Justice Institutions, January 1990.


National Aboriginal and Islander Legal Service, Submission to the Royal Commission Into Aboriginal Deaths in Custody, Preliminary Results of Interviews with Aboriginal Prisoners in NSW Gaols, undated.

National Association for the Care and Resettlement of Offenders (UK) Mothers and Babies in Prison, June 1985.


NSW Department of Corrective Services, Special Care Unit, Information Booklet 1981-1988.


NSW Department of Family and Community Services, Annual Report, 1988-89.

NSW Department of Family and Community Services, Royal Commission into Aboriginal Deaths in Custody, Departmental Background Information on Juvenile Justice, June 1990.


U.S. Department of Justice: *Basic rights of inmates Federal standards for prisons and gaols 1980, appendix D 1. Inmate rights*


Youth Justice Coalition (NSW), *Kids in Justice: A Blueprint for the 90's (Full Report)*, 1990

PART TWO

THE CARE PROVIDED BY THE PRISON MEDICAL SERVICE TO PERSONS DETAINED IN JUVENILE JUSTICE INSTITUTIONS
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>2.0 INTERNATIONAL STANDARDS</td>
<td>2</td>
</tr>
<tr>
<td>3.0 LEGISLATION</td>
<td>3</td>
</tr>
<tr>
<td>4.0 REVIEWS RELATING TO JUVENILE JUSTICE SERVICES</td>
<td>3</td>
</tr>
<tr>
<td>4.1 Royal Commission Into Aboriginal Deaths in Custody</td>
<td>4</td>
</tr>
<tr>
<td>4.2 Youth Justice Coalition Report</td>
<td>4</td>
</tr>
<tr>
<td>4.3 Report to the Director-General of FACS</td>
<td>4</td>
</tr>
<tr>
<td>5.0 POPULATION OF JUVENILE JUSTICE INSTITUTIONS</td>
<td>6</td>
</tr>
<tr>
<td>5.1 Current Population</td>
<td>6</td>
</tr>
<tr>
<td>5.2 Future Population</td>
<td>6</td>
</tr>
<tr>
<td>6.0 HEALTH NEEDS OF YOUNG OFFENDERS</td>
<td>7</td>
</tr>
<tr>
<td>7.0 GENERAL SERVICES PROVIDED TO YOUNG OFFENDERS</td>
<td>7</td>
</tr>
<tr>
<td>8.0 SPECIFIC SERVICES PROVIDED TO YOUNG OFFENDERS</td>
<td>8</td>
</tr>
<tr>
<td>8.1 Nursing Services</td>
<td>8</td>
</tr>
<tr>
<td>8.2 Medical Services</td>
<td>8</td>
</tr>
<tr>
<td>8.3 Psychological Services</td>
<td>8</td>
</tr>
<tr>
<td>8.4 Drug and Alcohol Services</td>
<td>9</td>
</tr>
<tr>
<td>8.5 Dental Services</td>
<td>9</td>
</tr>
<tr>
<td>9.0 COMMUNITY HEALTH SERVICES</td>
<td>9</td>
</tr>
<tr>
<td>10.0 PMS INVOLVEMENT</td>
<td>9</td>
</tr>
<tr>
<td>10.1 Standardised Service and Infrastructure</td>
<td>9</td>
</tr>
<tr>
<td>10.2 Improved Liaison with Medical Services</td>
<td>10</td>
</tr>
<tr>
<td>10.3 Evaluation and Accountability</td>
<td>10</td>
</tr>
<tr>
<td>11.0 PROBLEMS WITH PMS INVOLVEMENT</td>
<td>10</td>
</tr>
<tr>
<td>11.1 Major Differences in Adult and Juvenile Institutions</td>
<td>10</td>
</tr>
<tr>
<td>11.2 Appropriately Trained Staff</td>
<td>11</td>
</tr>
<tr>
<td>11.3 Institutionalised Structure</td>
<td>11</td>
</tr>
<tr>
<td>12.0 PROPOSED STRUCTURE FOR DELIVERY OF HEALTH SERVICES TO YOUNG OFFENDERS</td>
<td>11</td>
</tr>
<tr>
<td>21.1 Standing Committee</td>
<td>12</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>RECOMMENDATIONS</td>
<td>13</td>
</tr>
<tr>
<td>FOOTNOTES</td>
<td>14</td>
</tr>
<tr>
<td>APPENDIX A</td>
<td>15</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>16</td>
</tr>
<tr>
<td>MEETINGS ATTENDED</td>
<td>17</td>
</tr>
</tbody>
</table>
SUMMARY

PART TWO - SERVICES PROVIDED BY THE PRISON MEDICAL SERVICE TO PERSONS DETAINED IN JUVENILE JUSTICE INSTITUTIONS

At the time that the Committee commenced its review, responsibility for Detention Centres was with the Department of Family and Community Services. Following a re-structuring of Government services, responsibility for their administration has been transferred to the Department of Corrective Services, with policy development being the responsibility of the Attorney-General's Department.

Juvenile Justice Institutions, more commonly called Detention Centres, accommodate up to 450 young offenders in NSW. In 1990 it was announced that the Prison Medical Service (PMS) would provide medical services to young offenders. A contract for a period of 12 months was negotiated between the PMS and the Department of Family and Community Services, which at that time had responsibility for these centres.

The Committee strongly believes that young offenders are distinctly different from people in adult prisons, have different needs and perspectives and require different programs, facilities and treatments. Accordingly, the Prison Medical Service is not the appropriate organisation to deliver health services to young offenders, and the needs of this group should be met by a distinct, specialised service.

The PMS is an institutionalised service and has little expertise in delivering health care to young offenders. In contrast, the Royal Alexandra Hospital for Children has an Adolescent Health Unit with an outreach program. Its staff have considerable expertise in dealing with disturbed adolescents. The Chief Executive Officer of the Hospital has agreed in principle to its involvement in delivery of services to this group. The Committee believes that this hospital is the appropriate organisation to administer the delivery of health services to juvenile justice institutions, subject to the direction of a Standing Committee, established to develop policy for this service and to oversee service delivery.

This arrangement would best meet the needs of young offenders for health services.
MEDICAL SERVICES
IN JUVENILE JUSTICE INSTITUTIONS

1.0 INTRODUCTION

The terms of reference for this Committee include a review of medical services provided by the Prison Medical Service (PMS) to Juvenile Justice Institutions. These institutions, which accommodate young offenders, are more commonly called Detention Centres, and this term will be used throughout this report. At the time the review was commenced, responsibility for these institutions lay with the Department of Family and Community Services (FACS). Following restructuring of Government Departments in June 1991, it was initially advised that responsibility for these institutions would pass to the Attorney-General’s Department. More recently, it was advised that responsibility for operational and administrative aspects would pass to DOCS, and responsibility for policy would pass to the Attorney-General’s Department. At the time of writing, administrative arrangements relating to these portfolios are still unclear. The Committee’s view is that although the provision of medical care to Detention Centres raises some concerns common to the review of services to adult gaols, these services warrant separate examination and a separate report.

Young people detained in Detention Centres are a distinctly different group from those in adult prisons. Accordingly, they have different needs and perspectives and require different programs, facilities and treatments.

As the Australian Law Reform Commission states:

"There is almost universal acceptance of the principle that juveniles are not to be equated with adults. It is part of modern wisdom that children progress through a number of developmental stages and that, during these stages, children think, act and feel differently from adults. Therefore it is unrealistic and unjust to hold them to the same standards or treat them in the same way (as adults), even though, ultimately, they will be expected to adhere to adult law abiding values."[1]

It cannot be assumed that the needs of young offenders are catered for by a system designed to meet the needs of adult offenders. Different criteria are utilised to evaluate the two different services. There is a danger that these differences may be ignored if the two types of offenders are dealt with as a single group.

In relation to health services, a previous review commented on the different "culture" which is said to exist in juvenile justice institutions as against adult gaols. It was stated in the report that in comparison with gaols, there is a much greater element of obvious caring interaction between youth workers and residents, and that the "them and us" attitude universal in adult gaols is not seen.[2] In discussions with the Committee, Mr David Marchant, Deputy Director-General of the then Department of Family and Community Services, also referred to the importance of the distinction in cultures of the two organisations.
The involvement of the PMS in providing medical services to juvenile justice institutions is very recent. Following drug-related deaths of four young women from Reiby Detention Centre, in 1990 the Minister for Health and the Minister for Family and Community Services at that time jointly announced that the Department of FACS would contract with the PMS to provide medical services. A contract between FACS and the PMS for an initial period of 12 months was then negotiated.

Given that this contract has almost been completed and that new administrative arrangements apply, the Committee believes that the question of whether the PMS is still the most appropriate organisation to deliver health services to young offenders should be re-examined. The Committee believes strongly that the answer to this question is no, and that there are now more appropriate alternatives which should be adopted. The PMS has little expertise in dealing with young offenders. Few, if any, of its staff have training or experience in child or adolescent health issues. The PMS is an institutionalised service and the use of such a service to meet needs of young offenders runs counter to the philosophy that these young people should develop links with existing community resources. The development of such links is vital for a number of reasons. It teaches young offenders skills in utilising services, is consistent with the principle of normalisation (that is, that as far as possible, young offenders should be treated in a similar manner to non-offenders) and assists in achieving reintegration of young offenders into the community on release.

These arguments apply whether administrative responsibility for Detention Centres is with DOCS or the Attorney-General’s Department.

2.0 INTERNATIONAL STANDARDS

As with adult gaol services, juvenile justice centres are bound by UN principles and other international instruments dealing with medical services.

Australia has recently become a signatory to the UN Convention on the Rights of the Child. In relation to medical services, the Convention recognises the right of the child to the enjoyment of the highest attainable standard of health and to medical and rehabilitation facilities. The Convention states that State parties “shall take appropriate measures to ensure the provision of necessary medical assistance and health care to all children, with the emphasis on the development of primary health care”.

Other international standards address the issues of detention of young people. Most relevant is the principle:

"Every juvenile has the right to adequate medical care, both preventive and remedial, including dental and ophthalmological and mental health care, as well as pharmaceutical products and special diets as medically indicated". (3)
3.0 LEGISLATION

Under the Children (Detention Centres) Act, there is no formal organisation established to provide medical care to young offenders.

However, section 14 of that Act states:

"The Director-General shall ensure that adequate arrangements exist

(a) to maintain the physical, psychological and emotional well-being of detainees".

Section 25 provides that a detainee may, by order of the Director-General, or in cases of emergency by order of the Superintendent of the Detention Centre, be removed to a hospital or other specified place, for medical treatment.

Regulation 7 under that Act provides that:

(1) each detainee shall be supplied with such medical and dental treatment as, in the opinion of the medical officer or dental officer, is necessary to promote and maintain the detainees health and well-being.

(2) as soon as practicable after being admitted to a detention centre, each detainee should be subjected to a medical examination, and the state of his or her health recorded.

Under the regulation, the term "medical officer" in relation to a detention centre, means a registered medical practitioner who is approved by the Director-General as a medical officer for the Detention Centre. "Dental officer" has a corresponding meaning. (Clause 3).

Superintendents are to carry out a medical officer's recommendation so far as is reasonably practicable, where a medical officer recommends that a detainee's employment, diet, exercise or other treatment should be varied or modified for reasons of health.

4.0 REVIEWS RELATING TO JUVENILE JUSTICE SERVICES

The criticism is often voiced that prisons are subject to limited scrutiny by outside organisations and are seen as a low priority by many members of society. The Committee believes that medical services within gaols are paid even less attention than prisons on the whole. It is noticeable that juvenile detention centres, and medical services within those centres, are even less frequently reviewed by independent agencies. There may be a number of reasons for this, but the fact that the population is far smaller (approximately 400 compared to over 6,000 adults - see below) must be significant.

There were however three reports in 1990 which touched on or reviewed this area.
4.1 Royal Commission Into Aboriginal Deaths in Custody

In the Royal Commission's Report of Inquiry into the Death of Thomas Carr, the Commission stated that issues relating to facilities at juvenile institutions, dealing with medical, psychological and psychiatric assessments were likely to be considered by the Commission.

The Royal Commission's final report commented that the three deaths investigated by the Royal Commission which occurred in juvenile detention centres:

"all highlight similar issues relating to the identification and care of those at risk as were highlighted by the adult deaths which occurred in prisons. These include: the need for close and careful supervision, particularly for those identified as at risk; the need for a safe physical environment; the importance of human interaction between case workers and detainees; the need for adequate support systems for detainees, and particularly access to family and friends and the need for ready access to medical and psychiatric care."

No specific recommendations were made in the area, other than to state that the practices and procedures operating in juvenile detention centres should be reviewed in the light of the principles underlying the recommendations relating to police and prison custody in the Royal Commission's report, with a view to ensuring that no lesser standards of care are applied in such centres.

4.2 Youth Justice Coalition Report

The Youth Justice Coalition is a group of legal, youth and welfare workers concerned with juvenile justice issues. Its report was published in 1990, and focused on the experiences and perspectives of the users of the system - primarily, young offenders and their families. The report did not deal expressly with formal medical services available to young people but was critical of the lack of drug and alcohol treatment programs, and of the lack of appropriate counselling available to young offenders in Detention Centres. It recommended that:

- procedures and training be developed to ensure staff are in a position to identify promptly and treat appropriately drug-affected and addicted young people on admission to detention centres.

- Drug and alcohol programs should wherever possible, link to adequately resourced outside services including those operated by FACS through CYCs (Community Youth Centres) or other services, or through community-based or voluntary programs (e.g. Narcotics Anonymous).

4.3 Report to the Director-General of FACS

In January 1990, Dr McLeod and Mr Carmody of the PMS issued a Report to the Director-General of Family and Community Services on Health Services to Juvenile Justice Institutions. This appears to be the only review conducted of health services
to young offenders.

The report concluded:

"there are minimal to no effective psychiatric services available to young offenders"

"there is a marked lack of coordinated and cohesive health care service offered to clients of juvenile justice institutions in NSW"

"it would not be difficult to mount the argument that international standards relating to health care for imprisoned persons are not being met in Juvenile Justice units".

It also made a number of recommendations covering:

- introduction of a standard protocol and policy for hospital admission for withdrawal/detoxification

- availability of 24 hour nursing service where intoxicated young people are admitted

- appointment of Drug and Alcohol workers and introduction of appropriate Drug and Alcohol programs

- ensuring availability of a consistent psychiatric service to inmates in FACS institutions

- development of a juvenile Forensic Psychiatric Unit

- review of "holding rooms"

- provision of nursing services to all institutions, development of job descriptions, pay awards, and continuing education for nurses

- review of dental installations.

The most significant recommendation, for the purposes of this review was that:

- consideration be given by FACS to request the Department of Health to expand the role of the PMS to encompass the provision of health care to juvenile justice institutions.

Partly, although not exclusively, as a result of this report, it was agreed that PMS staff would provide services to Detention Centres on a contractual basis. Nurses previously working in FACS institutions are now accountable to the PMS. This arrangement is discussed in more detail below.
The Committee understands that there is 24 hour nursing care "on-call" in all institutions.

5.0 POPULATION OF JUVENILE JUSTICE INSTITUTIONS

5.1 Current Population

The juvenile justice system serves a much smaller population than the adult correctional system. The current number of young people detained in Detention Centres is estimated to be around 420, of whom approximately 120 are on remand. Detention Centres currently have a capacity to house 470 young offenders.

Offenders may be aged from 10 years to 21 years, but in practice, most are around 16 years of age. Approximately 25% of this population is Aboriginal.

There is provision in the Prisons Act for transfer of young offenders to Detention Centres, and similarly, some young offenders over 16 may be transferred from them to prison (s.28 Children (Detention Centres) Act) or remanded to prison (s.28A).

5.2 Future Population

The Sentencing Act and law and order policies which affect the populations of adult gaols have also had an effect on the number of juvenile offenders in institutions and the lengths of their sentences served.

The Report of the Youth Justice Coalition identified the following trends in juvenile justice:

- the creation of new offences and increased penalties for behaviour that is typically committed by juveniles;

- proposals that would blur the distinctions between Children’s Courts and adult courts;

- increased maximum terms for bonds and probation orders;

- greater numbers of transfers of children from detention centres to adult prisons;

- much greater emphasis on security and discipline in institutions;

- increasingly high proportions of young people from minority groups, particularly Aboriginal young people, incarcerated in juvenile detention centres and adult prisons;

- rapidly increasing periods for children in custody in detention centres, police cells and adult prisons; and

- increased numbers of young offenders being transferred and dealt with in adult
These trends are likely to increase the population of juvenile justice institutions and therefore the demand for medical services. However they are also likely to result in a greater number of young people in adult gaols.

Mr Laurie Maher, previously of the Department of FACS, has commented that in "recent months" there had been no need to transfer any detainee of under 18 years of age from a FACS institution to gaol, but that the Department has in fact been under pressure from courts and the Department of Corrective Services to accept increasing numbers of detainees under 21 years.

6.0 HEALTH NEEDS OF YOUNG OFFENDERS

As with adult offenders, it appears that there is limited data available on the health needs of young offenders. There is however evidence that a large proportion of the young people who enter the juvenile justice system are substance abusers, and their admission is often complicated by the need for detoxification. A number of the young people who enter the system may be classified as mentally ill or mentally disordered under the Mental Health Act 1990. Other juvenile offenders have conduct or behaviour disorders. In addition young people who enter the system need general health care and dental services.

Information on the health needs of young people indicates that:

- between 10-20% of young people aged less than 17 years are affected by a chronic illness or disability

- the incidence of sexually transmitted diseases among adolescents has increased markedly in the last 20 years

- approximately 10-15% of adolescents are considered to be moderately or seriously psychiatrically impaired.

A recent American study compared characteristics of children drawn from inpatient programs of a State operated psychiatric hospital for children and adolescents, with those of children in a juvenile corrections facility. The results supported the view that children with serious emotional disorders may be placed in correctional, as well as psychiatric hospital settings. It raised questions as to why children were placed in correctional rather than psychiatric facilities, and how children with serious behavioural and emotional problems might be more effectively served.

7.0 GENERAL SERVICES PROVIDED TO YOUNG OFFENDERS

As with adult prisoners, young people in Detention Centres are not covered by Medicare. At present, Area Health Services and Regional Health Services provide casualty, outpatient and inpatient services for young offenders at public hospitals.
Mental health services to juvenile offenders who have serious mental illness are provided by Area Health Services and Regions after negotiation with the institutions. Responsibility for juvenile offenders who have conduct or behaviour disorders is now with DOCS. Mental health assessment services may be provided to this group if requested. DOCS and and the NSW Department of Health share responsibility for juvenile offenders who have a dual diagnosis of developmental disability and mental illness. Child and Adolescent inpatient and community services provide pre-trial and pre-sentence assessments for juvenile offenders.

The AIDS Bureau of the Department of Health has funded projects specifically directed at the prevention and management of HIV infection in young offenders. An AIDS education video targeting young offenders was produced by the Health Media and Education Unit, and a FACS staff development project on HIV/AIDS was funded through the AIDS program.

A range of other specialist services such as accident and emergency, physiotherapy, X-rays, ultrasounds, orthopaedics, optometry, sports injury, and psychiatric services, is also available to young people in detention centres.

8.0 SPECIFIC SERVICES PROVIDED TO YOUNG OFFENDERS

8.1 Nursing Services

Nursing services include first aid, pathology, medication dispensing, vaccination programs, health education for detainees, assistance to visiting medical practitioners, and associated clerical work.

8.2 Medical Services

Visiting medical practitioners provide check ups and referrals to any specialist services required.

8.3 Psychological Services

The objectives for the provision of psychological services by FACS were stated to be:

"to provide a comprehensive specialist assessment and counselling service to children in both the care and control of the Department and a casework consultancy service to the Department’s field staff."(11)

Psychological services in FACS were reorganised in 1988-9. All psychologists previously attached to clinics were located at local district centres and residential care facilities to integrate the specialist services with the routine Departmental services and to increase the availability and access of such services to both children and staff.

Two deputy principal psychologists were appointed in 1988-9 to assist the principal psychologist with evaluation, training and supervising the professional work of all Departmental psychologists.
Psychologists were employed at all institutions apart from Riverina, although there was only 0.5 of a psychologist's time allocated at Keelong (Wollongong). Three psychologists were employed at Mt. Penang. These psychologists provide psychological reports for courts, and are involved in assessment and counselling of young offenders, psychometric assessments, case reviews, family assessments, staff education, program development and arrangement of psychiatric assessments or treatment. They also provide group sessions on issues such as social skills training, and develop casework plans for the young people detained.

The Committee understands that most of these psychologists have no clinical qualifications.

8.4 Drug and Alcohol Services

A Drug and Alcohol Worker is employed at all Detention Centres except Riverina and Worimi, and three Community Youth Centres also employ drug and alcohol counsellors.

These counsellors and workers provide drug and alcohol programs and counselling, drug and alcohol education programs for staff and detainees, drug and alcohol assessments, family counselling where appropriate and co-ordination of external drug and alcohol agency involvement.

8.5 Dental Services

Dental services include check-ups, therapy for those in need, and general dental health advice.

9.0 COMMUNITY HEALTH SERVICES

Community Health Centres, the Aboriginal Medical Service and groups such as Alcoholics Anonymous provide health services and programs to young offenders in Detention Centres.

10.0 PMS INVOLVEMENT

10.1 Standardised Service and Infrastructure

The suggestion that responsibility for health care of detainees be provided by the PMS was initially made in the report to the Director-General of FACS.

On this issue, the report stated:

"there already exists an established health care delivery system in the adult custodial setting, with the experience, core staff and general infrastructure to build an efficient system within FACS units."

The report noted that FACS staff were not opposed to the idea of transfer of
responsibility to the PMS, but that rather there was a "warm acceptance" of it.

"While not suggesting such a move would lead to an instant cure of all identified ills, given sufficient funding and lead time, it is contended that the PMS would markedly improve the present Health Care system in FACS secure facilities ...... Until some form of co-ordinated and standardised service is introduced, the problems will continue and not lessen as the contained population increases."

In the Committee's view, limited benefits flowing from a standardised service and existing infrastructure are outweighed by other considerations.

10.2 Improved Liaison with Medical Services

In discussions held by the Committee with senior administrative staff of FACS, reference was made to the advantages of having a medical practitioner available. It was said that such a practitioner would have a valuable role in liaising with community health services, particularly where such liaison involved difficult negotiations with other medical practitioners. For example, concern was expressed about difficulties in obtaining access to after hours medical care.

The Committee believes that these concerns are still relevant. Easier access to medical care will not necessarily follow as a result of PMS involvement. The Attorney-General's Department has no infrastructure to enable these links to be developed. In Part One of this report, the Committee has noted with concern that some medical services are not routinely available to adult prisoners. Even if this could be remedied in relation to young offenders following transfer of responsibility to DOCS, services provided by the PMS are not the most appropriate for this group.

10.3 Evaluation and Accountability

The Deputy Director of FACS stated that the contract with the PMS was for a limited term. It spelt out the obligations of both parties and provided a mechanism to allow greater accountability. Renewal of the contract was subject to favourable evaluation of services provided.

11.0 PROBLEMS WITH PMS INVOLVEMENT

11.1 Major Differences in Adult and Juvenile Institutions

At a philosophical level, there is a strong argument that juvenile offenders, by reason of their age, should not be exposed to the full rigor of the criminal law or custodial systems. This argument extends to the administration of health care. There are marked differences between the "culture" of detention centres and that of adult gaols. The Committee's view is that these differences are highly significant.

Direct responsibility by the PMS for medical services allows the possibility of juveniles being admitted to Long Bay hospital, and mitigates against the use and
development of appropriate options in community health services. The Committee strongly believes that the use of adult prison health facilities for juveniles should be avoided. Close links between the Prison Medical Service and the juvenile justice system may increase the likelihood of these facilities being used in the treatment of juveniles.

11.2 Appropriately Trained Staff

Appropriately trained staff are required to deal with the specific problems of young offenders, whose needs are markedly different from those of adults. The PMS has no specific expertise in the health care of children and adolescents. Psychiatric care is of particular importance. Child and Family Psychiatry is a sub-speciality of psychiatry and is not likely to be available from the general psychiatrists employed by the PMS.

The Committee strongly believes that staff of all disciplines who work in Detention Centres require appropriate training, and this training should be developed to take account of the specific needs and characteristics of young offenders.

11.3 Institutionalised Structure

Juvenile offenders are generally in institutions for short periods of time compared to adults. Every advantage needs to be taken to ensure that their rehabilitative needs are met while they are within the institution. As far as possible they should be made aware of services available in the general community. Knowledge of such services, and the development of skills in utilising them are important for the reintegration of young offenders into the community on release.

The Deputy Director-General of FACS stressed the need for young people in institutions to learn the skills to obtain access to these facilities and services. The Committee agrees that this is a very important aim.

The PMS operates as an institutionalised structure and provides what is largely an institutionalised service. Although it may have the capacity to develop links between community health services and juvenile justice institutions, these links have not been very well developed in the adult system. A formal role for the PMS may militate against community links being strengthened.

The view has also been put to the Committee that both staff (including health staff) and young people may become "institutionalised" after a period of time in a Detention Centre. This means that "outside" health care staff are in a position to provide a different approach to health care to young offenders, and to express alternative views.

12.0 PROPOSED STRUCTURE FOR DELIVERY OF HEALTH SERVICES TO YOUNG OFFENDERS

The Committee believes that it is inappropriate for the PMS to deliver medical services to young people in detention centres. When responsibility for medical services in these centres was transferred to the PMS in 1990, there were a number of
benefits to be gained. At that time, this was the option most likely to improve delivery of medical services to young offenders.

The Royal Alexandra Hospital for Children has an Adolescent Medical Unit with a good reputation. Through its Cell Block Unit, it provides outreach services which address the problems of disturbed adolescents. This service would appear to meet all the requirements for an optimal service to young offenders. It has considerable expertise in the area, has developed extensive networks and has links with community health services.

Preliminary discussions have been held with Dr John Yu, Chief Executive Officer of the Hospital, and he has agreed in principle to the involvement of the Hospital in providing services to young offenders. The Committee believes strongly that this is the most desirable option.

12.1 Standing Committee

There are strong arguments for the establishment of a formal structure to overview these services. As with the adult system, if health care is provided in a primarily custodial environment, there is the potential for custodial and health care objectives to conflict. A formalised structure would ensure increased accountability and also provide support and advice to health care staff.

The Committee therefore recommends that a Standing Committee be established by the Minister for Health Services Management, with responsibility for overseeing the delivery of health services to young people detained in juvenile justice institutions. It should consist of a representative of the Department of Health, a representative of DOCS, a representative of the Attorney General’s Department, a representative of the Royal Alexandra Hospital for Children and an independent community representative. The Standing Committee should develop policy for the delivery of health services to young people in detention centres.

In Victoria, a Young Offenders Health Board was established to coordinate the government’s response to the health needs of young people. It is supported by both the Health Department and Community Services Victoria (CSV), but it is recognised and accepted by both Departments and the Board that CSV has the primary responsibility for ensuring that adequate health care is available.

The Standing Committee is intended to facilitate coordination of existing services and access to general health services, and to develop plans for a collaborative approach to future developments. The Standing Committee would determine policy direction for young offender health services. It would further oversee the delivery of these services, including monitoring of resources, determining priorities and strategies and addressing major problems which arise.
RECOMMENDATIONS:

1. That the Minister for Health Services Management recommend to the Minister for Justice that health services for young offenders be provided by the Royal Alexandra Hospital for Children.

2. That negotiations be commenced immediately to achieve this objective.

3. That a Standing Committee be established to oversee the delivery of health care to young people in juvenile justice institutions.

4. That membership of the Standing Committee be a representative of the Department of Health, a representative of DOCS, a representative of the Attorney-General's Department, a representative of the Royal Alexandra Hospital for Children, and an independent community representative.

5. That the Standing Committee ensure that relevant recommendations made in the report to the Director-General of FACS be implemented and that appropriate standards be adhered to.
FOOTNOTES

erg, Fox and Hogan, Sentencing Young Offenders 1988, p67.
McLeod and J. Carmody, Report to the Director-General of Family and
Community Services on Health Services to Juvenile Justice Institutions, January 1990,
United Nations Draft Rules for the Protection of Juveniles Deprived of their

Commissions into Aboriginal Deaths in custody 1990, AGPS, Canberra, 1990,


Kids in Justice - A Blueprint for the 90's"

bid, p314.

ibid, p6.

"Policy and Trends in Relation to Juvenile Detention" Paper presented to Institute of

Cohen, R., Parmelee, D., Irwin, L., Weisz, J., Howard, P., Purchell, P., and Best, A.,
"Characteristics of Children and Adolescents in a Psychiatric Hospital and a

Department of Family and Community Services, Annual Report, 1988-89.
APPENDIX A - JUVENILE JUSTICE INSTITUTIONS SERVED BY THE PMS

Population at 30.9.90

<table>
<thead>
<tr>
<th>Institution</th>
<th>Location</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mt Penang</td>
<td>Gosford</td>
<td>175</td>
</tr>
<tr>
<td>Reiby</td>
<td>Campbelltown</td>
<td>52</td>
</tr>
<tr>
<td>Cobham</td>
<td>St Mary's</td>
<td>35</td>
</tr>
<tr>
<td>Keelung</td>
<td>Wollongong</td>
<td>25</td>
</tr>
<tr>
<td>Minda</td>
<td>Lidcombe</td>
<td>40</td>
</tr>
<tr>
<td>Riverina</td>
<td>Wagga Wagga</td>
<td>17</td>
</tr>
<tr>
<td>Yasmar</td>
<td>Haberfield</td>
<td>26</td>
</tr>
<tr>
<td>Worimi</td>
<td>Newcastle</td>
<td>34</td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY


McLeod F., and Carmody J., Report to the Director-General of Family and Community Services on Health Services to Juvenile Justice Institutions, January 1990.


MEETINGS ATTENDED

The Committee held meetings with the following people:

- Mr John Howard, School of Behavioural Sciences, Macquarie University.
- Professor Brent Waters, Avoca Clinic, Prince of Wales Children's Hospital.
- Staff of Mt Penang Detention Centre.
- Mr David Marchant, Deputy Director-General, Department of FACS, and Mr Terry Samways, Operations Director, Department of FACS.
- Dr John Yu, Chief Executive Officer, Royal Alexandra Hospital for Children.

The Committee also received information from Mr Michael Fitzpatrick, Manager, Operations Support Branch, Department of FACS.