A prisoner health information system

Information paper

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Abbreviations

ABS	Australian Bureau of Statistics
AIC	Australian Institute of Criminology
AIDS	Acquired Immunodeficiency Syndrome
AIHW	Australian Institute of Health and Welfare
BEACH	Bettering the Evaluation And Care of Health
HIV	Human Immunodeficiency Virus
NHDD	National Health Data Dictionary
NHIMG	National Health Information Management Group
NHMD	National Hospital Morbidity Database
NMDS	National Minimum Data Set
NNDSS	National Notifiable Diseases Surveillance System

Introduction

Throughout 2000, approximately 50,000 individuals were imprisoned in Corrections Services prisons. However, there are no national standards or agreements encompassing either the provision of health care to Australia's prisoners or the collection of information about their health. The provision of health services for prisoners is the responsibility of the State and Territory governments, where current health care practices vary substantially (see Attachment 1). At present, the collection of information about the health of prisoners is sporadic, inconsistent and incomplete.

This paper describes some of the issues associated with establishing a national prisoner health information system.

Why do we need information about prisoner health?

The collection of prisoner health information would be useful to inform prisoner health policies and programs and thus to improve the health of prisoners. Evidence of poor health among the prison population supports the need for such a collection (Butler 1997).

Prisoner health information is necessary:

- to monitor prisoner health, including trends and State and Territory comparisons;
- to identify areas for improvement in health ;
- to assess and evaluate the provision of health care services and disability and other support programs;
- to inform health service planning;
- to measure health policy outcomes among prisoners (e.g. the National HIV/AIDS Strategy, National Hepatitis C Strategy);
- to assess differences in health care between prisons, prison systems or prison providers; and
- to provide health performance indicators for correctional facilities.

This information is vital for public health, both within prisons and for the wider community. Inmates form a closed community within which health problems can be readily created (e.g. mental health) and/or transmitted (e.g. communicable diseases). Poor prisoner health may also affect the health of the wider community upon prisoner release or by transmission to visitors or prison staff.

Who is interested in prisoner health?

A number of groups are interested in prisoner health, some due to legal obligation (e.g. government departments), others as a result of their involvement with prisoners within the prison system (e.g. clinicians, prison staff) or on their release (e.g. the community) and still others that monitor human rights. Each group has a particular interest in prisoner health information.

Numerous government departments have a use for prisoner health information to assist the administration of their programs. The State and Territory governments are responsible for the health of prisoners in their jurisdictions. Once prisoners are released back into the community, all levels of government have a role in their health.

Departments with an interest in the collection of prisoner health information could include:

- at the State and Territory level
  - –Attorneys General Departments
  - –Departments or Ministries of Justice
  - –Departments encompassing Family Services
- at the Commonwealth level
  - –Department of Health and Aged Care
  - –Department of Family and Community Services
  - –Attorney General's Department.

Where do we currently get information about prisoner health?

The limited information available about the health of Australia's prisoners comes from a range of sources, which, to date, have not been integrated.

Currently, there are no national data on the health of prisoners in Australia. However, detailed data are available from some State based surveys. The most comprehensive of these was the 1996 New South Wales Inmate Health Survey, due to be repeated in 2001. Victoria is currently developing a similar survey (which will allow comparison with NSW), also due to be conducted in the later months of 2001.

Information on the causes of deaths in prisons is published by the Australian Institute of Criminology (Dalton 2000). This information is also included in the Productivity Commission's Report on Government Services, as the only health-related performance indicator for prisons (SCRCSSP 2001).

The annual prison census provides information on the demographic and crime characteristics of prisoners, but does not provide any information about their health. The prison census is a compilation of administrative data collected from corrective services agencies in each State and Territory by the Australian Bureau of Statistics. Before 1994, this was collected by the Australian Institute of Criminology.

Information on Human immunodeficiency virus (HIV) testing on admission/reception to prison is collected and published by the National Centre in HIV Epidemiology and Clinical Research (National Centre in HIV Epidemiology and Clinical Research 2000). The State and

Territory Departments of Corrections have provided these data since 1991. However, coverage is not complete as testing is not mandatory: for example, in 1999, only 58% of prisoners were tested upon admission/reception.

Various epidemiological studies focusing on prisoner populations have also collected data on specific conditions and diseases, for example, *The Epidemiology of Hepatitis C Infection in Prison Populations* (Dolan 2000*), Hepatitis B and C in New South Wales Prisons: Prevalence and Risk Factors* (Butler et al. 1997), and *Spread of Bloodborne Viruses Among Australian Prison Entrants* (Crofts et al. 1995).

What do we know about prisoner health?

The limited information available indicates that prisoners form a sub-group of the population. Many prisoners have led risky lifestyles and were disadvantaged before imprisonment. In New South Wales, the majority of inmates were not employed in the six months before imprisonment, and around half have no education or trade qualifications. Around half of inmates reported that they consumed 'harmful' quantities of alcohol before imprisonment (Butler 1997).

Although the prison environment changes an individual's lifestyle and can eliminate some health risks, other health risks are not eliminated and some are increased: for example, almost three-quarters of prisoners in New South Wales currently smoke (Butler 1997). Prisoners are also at increased risk of contracting communicable diseases. In New South Wales, in 1996, 69% of men and 64% of women reported sharing needles in prison. One third of male and two thirds of female inmates tested positive for the hepatitis C antibody (Butler 1997). In Australia's prisons, prevention measures such as condoms, dental dams and clean needles are either not available or not widely available. Prisoners can also suffer from drug withdrawal, as methadone replacement programs are not widely available.

Prisoners face the threat of violence. In 1997–98, homicide accounted for 11% of prison deaths (Dalton 1998). Prisoners also endure mental and emotional stress, which can lead to suicide. In 1997–98, suicide accounted for 53% of all deaths in prisons (with all but one of these by hanging) compared to 2% of all deaths in the general population. Unsentenced prisoners are at a higher risk of death in custody than sentenced prisoners. In 1999, unsentenced prisoners represented 15% of the prisoner population, but 36% of deaths in prison custody (Dalton 2000).

In the general population there are large differences between the health of the Indigenous population and the non-Indigenous population across a range of health status measures. There are inadequate data to determine the applicability of this statement to the incarcerated population, however the Royal Commission into the Aboriginal Deaths in Custody (1991) made specific recommendations to improve the health of Indigenous prisoners. Data show an over-representation of Indigenous people in prisons. According to the 1996 Census, Indigenous people represented 2.1% of the total Australian population, whereas Indigenous prisoners account for 20% of the prison population (1999–2000). The imprisonment rate for the Indigenous population in 2000 was 1,738 per 100,000 adults, compared with 117 per 100,000 adults for the non-Indigenous population (SCRCSSP 2001). However, these data may underestimate the true imprisonment rate, as identification of Indigenous peoples is often deficient. To enable valid and reliable information and comparisons, the accuracy of the recording of the identification of Aboriginal and Torres Strait Islanders among the prison population could be investigated.

The population with disabilities is also estimated to be over-represented in prisons. In New South Wales it is estimated that 12–13% of inmates have an intellectual disability, compared with 2–3% of the general population (New South Wales Law Reform Commission 1994; AIHW 1999b). In 1996, mental disorder was the second most common reason for hospitalisation among NSW inmates in the last 12 months (Butler 1997). Prisoners with disabilities have special needs in relation to health care, information, programs and support services. Prison officers also often require special training in order to provide adequate care to prisoners with disabilities.

As is the case with the Australian population, data from the prison census demonstrate that the prisoner population is also aging. This could effect corrective services health care, as older people are likely to increase the demand for, and the cost of, health services.

Prisoner health information system

Aim

The primary aim of a prisoner health information system would be to collect nationally consistent information on the health and risk factor status of prisoners, their health care needs and health service usage.

A prisoner health information system should also collect information that could be used for further investigations including:

- changes to health and risk factor status during imprisonment;
- differences in health status between various population groups (e.g. males and females, Indigenous and non-Indigenous prisoners); and
- comparisons with the general Australian population.

Data definitions and items

Definition of prisoners

There are different ways of defining the prisoner population—by type of sentence, by type of prison custody or by age. The ABS (2000) uses the following definitions for prisoners and sentence type.

Prisoners	People held in custody whose confinement is the responsibility of a corrective services agency.
Sentenced	A legal status indicating that a person has received a custodial order from a court in response to a conviction for a criminal offence.
Unsentenced	A legal status indicating that a person is confined to custody while awaiting the outcome of their trial. Some sentenced prisoners are also remanded in custody, i.e. are unsentenced, in relation to other offences, pending a court hearing. In such cases, these prisoners are counted as sentenced.

The population included in a prisoner health information system could be limited to persons in adult public and private prisons within the corrective services system. However, the age of prisoners sentenced to adult custodial correction agencies varies between the State and

Territories. In Victoria, Queensland, Tasmania and the Northern Territory, people sentenced or remanded to adult custodial correction agencies are aged 17 years and over. In New South Wales, South Australia, Western Australia and the Australian Capital Territory, adult prisoners are aged 18 years and over. People aged under 17 or 18 years of age (depending on the State or Territory) are treated as juveniles in most Australian courts and are not remanded or sentenced to adult prisons, except in exceptional circumstances.

Information about people in adult private and public prisons would be relatively easy to obtain and compare with the general population. Nevertheless, the inclusion of juveniles and people in psychiatric hospitals, on periodic detention, serving community corrections, at work camps, on home detention, on parole, on probation or having completed their sentence, could also be considered.

Definition of health

A broad definition of health should be used for a prisoner health information system. The National Health Information Model (AIHW 2001) and a framework for health, such as that used in *Australia's Health 2000* (AIHW 2000b), could be used to determine which information should be collected. Elements of such a framework are:

- determinants of health
  - –environmental e.g. social circumstances, chemical exposure
  - –individual e.g. sexual behaviour, biomedical factors;
- disability;
- disease, impairments, symptoms and injuries;
- health interventions; and
- health resources.

This kind of information is routinely reported about the health of other population groups within the community (e.g. *Australia's Health 2000*, AIHW 2000b; *Australia's Youth*, AIHW 1999; *Australia's Welfare*, AIHW 1999b). Reporting similar information for the prisoner population would provide a more complete picture of the health of Australians and would also enable comparisons with other population groups.

Prisoner health information collections and minimum data set

Various methods of data collection would be required to determine the health and risk factor status, health care needs and health service usage of the prisoner population. Some methods are routine (i.e. administrative) and ongoing (providing longitudinal data), while others have a particular focus and are periodic (providing cross-sectional data).

Admission/reception data

The Standard Guidelines for Corrections in Australia (Conference of Correctional Administrators 1996: see also Attachment 2) states the need for admission/reception medical examinations to be conducted as soon as possible after a prisoner is received into prison.

In accordance with these guidelines, health information is currently collected from all people upon imprisonment (both sentenced and unsentenced). However, questions and tests differ between the jurisdictions. For example, testing for HIV at admission/reception to prison is voluntary in New South Wales, Victoria, Queensland, Western Australia and the Australian Capital Territory, but is compulsory in the other States and the Northern Territory. In addition, many factors can influence the reliability of general health information obtained from prisoners at admission/reception, such as trauma, drug withdrawal and confusion or mistrust about the purpose of collecting the information.

Admission/reception health information is a useful source for assessing acute needs (e.g. drug treatment, suicide risk). Yet, approximately 36% of prison deaths in 1999 were among unsentenced prisoners (Dalton 2000). Some jurisdictions are currently reviewing the forms used and the information collected, however, a national evaluation of data collection instruments could be introduced. Such an evaluation could investigate the capacity to predict suicide risk and the reliability of other health information. This could enable the development of 'best practice' in terms of assessment of acute needs and service delivery.

The level of computerisation of admission/reception health information differs between jurisdictions, varying from fully computerised, in the process of being computerised or only partly computerised, to assessment of possibilities for computerisation.

Annual medical examinations

Annual medical examinations are not mentioned in the Standard Guidelines for Corrections in Australia (Conference of Correctional Administrators 1996) and are not routinely carried out in Australian prisons. In some jurisdictions medical examinations are available annually at the request of the prisoner while in other jurisdictions examinations are sporadic or opportunistic. Records from annual medical examinations prisoners, if they were standardised and accessible, would be useful for research (particularly for cohort studies) and monitoring the health of long-term.

The collection of such information would require the implementation of routine annual examination of all, or subsets of, prisoners (e.g. prisoners sentenced for more than one year, prisoners identified as at risk), computerisation of data and appointment schedules as well as a national protocol including consistent tests, questions and measurements.

Many prisoners are imprisoned for relatively short periods, and would therefore be missed if an annual schedule were used. For example, in Tasmania, 75% of inmates are in custody for less than three months, and in New South Wales the average length of stay is

6–7 months. However, recent information about the health of prisoners would be available, as it would have been collected upon admission/reception.

Medical records

Medical records include detailed information from medical practitioner consultations, casualty/outpatient visits and hospitalisations. At present, only the Northern Territory has computerised medical records describing these encounters. National, standardised, computerised medical records would be a valuable component of a prisoner health information system.

A model for collecting information on health professional encounters is the Bettering the Evaluation and Care of Health (BEACH) study of general practice activity (Britt et al 1999). BEACH includes information about reasons for encounter, problems managed, pathology tests, imaging tests, medication and referrals, and has protocols that may be of use in a prison environment.

Hospital separations

Prisoners throughout Australia are treated in prison, public or private hospitals, depending on the specific arrangements for hospitalisation of prisoners made by the various State and Territory corrections services.

A hospital separation is defined as an episode of care for a patient admitted to hospital. Every jurisdiction has a hospital morbidity database on which this information is stored. A core set of variables from these databases is combined to form the National Hospital Morbidity Database (NHMD), held at the Australian Institute of Health and Welfare. The NHMD includes information on demographics, principal diagnosis and other diagnoses, external causes of injury and poisoning, procedures, diagnosis related group and length of stay for each hospital separation.

The identification of prisoners in the NHMD and all jurisdiction morbidity databases is expected in the 2001–02 collection. The addition of a new data item on funding source for the 2001–02 collection will allow the identification of hospital separations funded by Departments of Corrective Services. Information about hospital separations for prisoners would enable comparisons with the general population and specific population groups.

For collections before and including 2000–01, the identification of separations for prisoners in the NHMD was limited to separations from New South Wales prison hospitals. However, some jurisdictions are able to identify prisoners among separations in previous years' collections (and this will continue in the future), using other information

- In New South Wales, information is available on separations from prison hospitals and, since July 2000, information has been collected on financial class, which allows the identification of prisoners among separations from public hospitals.
- In Victoria, hospital separations data include a specific code to identify prisoners.
- In Queensland, prisoners can be identified among separations using a source of referral data item.
- In Western Australia, four data items assist with identification—address of patient, source of referral, admitted from and discharged to locations.
- In the Northern Territory, identification of prisoners is possible using a financial classification data item.

South Australia, Tasmania and the Australian Capital Territory are unable to identify prisoners among separations on previous years' jurisdictional morbidity collections. Further, information about admissions to a prison hospital in Tasmania is not included on that jurisdiction's morbidity database and thus is not included in the NHMD. It would be useful if this data could be collected for inclusion in the NHMD.

Communicable disease notifications

Communicable disease is an important area of prisoner health. People in custodial settings have been identified as a priority group for the National HIV/AIDS Strategy and the National Hepatitis Strategy. These and other communicable diseases are notifiable to the State and Territory Health Authorities, who in turn forward the information to the National Notifiable Diseases Surveillance System (NNDSS). At present the data collated by the NNDSS do not include a prison identifier, however, some jurisdiction Health Departments can identify notifications from prisons on their databases.

A central repository of notifications of inmates with communicable diseases could be established. The computerisation of medical records would facilitate notifications to the NNDSS.

Surveys

Surveys are a means of overcoming deficiencies in health service, admission/reception and annual medical examination data. They offer the opportunity to collect information about prisoner health at a relatively low cost ,and can identify key issues for health management. Another advantage is that surveys can focus on certain types of prisoners.

National surveys with a core set of questions and tests, which could be supplemented by State and Territory specific questions, could be devised. Health surveys could be conducted either independently or in conjunction with other surveys as a means of minimising costs (if the methodology and sample are appropriate). The Australian Institute of Criminology, for example, has just completed a survey of male sentenced prisoners in four jurisdictions, Drug Use Careers of Offenders (DUCO). This might be extended to include females and juveniles.

Methodologies for prisoner surveys already exist, and sharing of these methodologies is already occurring. The 2001 New South Wales Corrections Health Service Inmate Health Survey has recently been reviewed for its applicability to Victorian prisoners, where a similar survey will be conducted in late 2001. This will enable comparisons on the health status of prisons in New South Wales and Victoria. South Australia and Western Australia are currently considering proposals to conduct similar surveys.

Expenditure and resources

National public health expenditure information does not currently include expenditure on all health services provided to prisoners, nor is there a central system for recording these data.

The feasibility of including data on expenditure and resources used in the delivery of health services to prisoners in the prisoner health information system needs to be investigated. Currently, the provision and funding arrangements of prison health services differs between jurisdictions.

Difficulties may be experienced in collecting expenditure data due to issues around the 'commercial in confidence' classification for the reporting of expenditure and resources used for the delivery of primary health care in private prisons or in public prisons where this service has been contracted out.

National Minimum Data Set

A National Minimum Data Set (NMDS) is a minimum set of data elements agreed by the National Health Information Management Group (NHIMG) for mandatory collection and reporting at the national level.

The production of a prisoner health NMDS would be contingent upon a national agreement to collect and supply uniform data as part of a national collection, but would not preclude agencies and service providers from collecting additional data to meet their own specific needs (AIHW 2000a). The development of an such an NMDS would involve a wide range of stakeholders.

To facilitate a prisoner health information system, a Prisoner Health NMDS should be developed with data elements consistent with the National Health Data Dictionary (NHDD) (AIHW 2000a). This would allow comparability with health information that is available for the general population. The data elements in a prisoner health NMDS could be applied to a range of data collection methods as described above. Prison health –specific data items could be put before the NHIMG and its technical group (the National Health Data Committee) for inclusion into the NHDD.

Work has already commenced on a Juvenile Justice NMDS. A report on the development of the data set has recently been produced by the AIHW (in press, Broadbent), as the first step in the process. At a later stage the Juvenile Justice NMDS could be further developed to include health data that could be incorporated into a more comprehensive prisoner health information system.

Further development of other NMDS could also enhance the prisoner health information system. The NMDS for alcohol and other drug treatment services is one such example, as the Intergovernmental Committee on Drugs Working Group is currently discussing the possibility of adding correctional services facilities to the treatment delivery setting category.

Discussion

All of the collections outlined above have both strengths and weaknesses. A prisoner health information system would benefit from the incorporation of elements from all of these collections. Each collection provides information about different aspects of prisoner health, and together the data would provide a good picture of prisoners' health status, health care needs and health service usage.

The compilation of timely prisoner health information into a standardised national collection would facilitate monitoring and comparisons within and across jurisdictions and with the general Australian population. It would also assist in completing the picture of health for all Australians.

A national collection of prisoner health information could be made available to researchers under privacy protocols that maintain confidentiality. This model is currently in place for a range of health data collections (e.g. cancer, mortality, hospital morbidity) under the *Australian Institute of Health and Welfare Act 1987*. The protection of prisoners' information within jurisdictions can also be achieved under State and Territory specific legislation. It is worth noting that there are reviews of privacy legislation and data management guidelines currently underway across all jurisdictions (these will need to be taken into account in developing a prisoner health information system).

One critical element in the development of a prisoner health information system is investment in information technology infrastructure and staff. Such infrastructure assists in recording, storing, analysing and transferring data. In most jurisdictions, the infrastructure is either non-existent or require development.

Guiding the development of a prisoner health information system is also critical. Mechanisms for drawing together stakeholders to discuss prisoner health information need to be found and should involve not only prisoner health specialists but also population health researchers and information managers.

The establishment of a prisoner health information system is a complex and evolutionary process. Investment in such a system would provide useful information for the management of prisoner health. This paper has identified some of the key issues involved in setting up such a system, and encourages debate about them. From these issues a series of recommendations have been formed to assist in promoting the development of a prisoner health information system.

Recommendations

A comprehensive national prisoner health information system should be established with the following elements: standardised data from surveys, admission/reception and annual examinations, medical records, hospitalisations and general practice encounters.

This would be facilitated by creating a steering group to oversee the development of a prisoner health information system. This group should include representation from all jurisdictions and relevant departments. The steering group should develop plans to implement the following steps.

- Creating a National Minimum Data Set (NMDS) for information collected upon admission/reception, and subsequently incorporating information collected during annual examinations. The NMDS could be registered in the AIHW's *Knowledgebase* which incorporates the National Health Data Dictionary.
- Introducing a standard form to record health information from each encounter with general practitioners. The BEACH form could be used as a model, as it is currently in use in Australia and would provide comparability with the general population.
- Coding, and collection of, health information in prison hospitals, for inclusion in the National Hospital Morbidity Database.
- Supplementing administrative data with national prisoner health surveys. Surveys should collect information consistent with the National Health Data Dictionary. National surveys could be overseen by the Australiasian Council of Prison Health Services and supported by the National Public Health Information Working Group.
- Ensuring that all health data collected is stored in an electronic format for the purposes of information analysis and exchange. De-identified data should be made available for analysis, with appropriate protection for these data under current privacy legislation.

Attachment 1

Current provisions of health care for prisoners

The provision of health services for prisoners is the responsibility of State/Territory governments. Health services are either delivered directly by jurisdiction governments, purchased through contractual arrangements or provided through a combination of the two.

- In New South Wales, health care is provided by the Corrections Health Service (funded by the New South Wales Health Department).
- In Victoria, all prison providers are responsible for the provision of primary health care services within their own prisons. Prisoners requiring secondary and tertiary health care services are treated at the Port Phillip Prison (men) or at St Vincent's Hospital or the Royal Women's Hospital (women).
- According to the *Queensland Corrective Service Act*, general managers of prisons are responsible for providing such medical services as are necessary for the welfare of prisoners.
- In Western Australia, the Ministry of Justice provides health services to prisons. All prisons include a medical centre/nursing post. Prisoners requiring hospital treatment are referred to the public hospital system.
- In South Australia, health care services are provided by the Royal Adelaide Hospital (under a Memorandum Of Understanding with the Department of Corrective Services).
- In Tasmania, health care services are provided by the Department of Health and Human Services. Prisoners requiring acute hospital treatment are referred to the public hospital system.
- Sentenced adult prisoners from the Australian Capital Territory are held in New South Wales prisons. Australian Capital Territory Community Care and Mental Health Services (under an agreement with the Australian Capital Territory Department of Health, Housing and Community Care) provides health services for remand prisoners.
- In the Northern Territory, primary health care is provided through open tender medical contracts. Services not included in the primary health care program are provided by Territory Health Services.

Attachment 2

Health policy, guidelines and standards

Policies that effect prisoner health may be statewide general health policies or prison – specific policies. For example, as part of the Northern Territory's hepatitis B Vaccination Policy, long–term inmates of correctional facilities are provided with free hepatitis B vaccinations. Smoking restrictions are an example of a prison specific policy.

An outcome of the 1995 Corrections Ministers' Conference was the development of Standard Guidelines for Corrections in Australia (Conference of Correctional Administrators 1996). These are based on a United Nations resolution on 'Basic principles for the treatment of prisoners', adopted and proclaimed by the United Nations general assembly in December 1990.

A section of the Standard Guidelines for Corrections in Australia pertains to health services. There are 14 health service guidelines including: the need for at least one medical officer being available 24 hours per day and admission/reception medical examinations being conducted as soon as possible after being received and thereafter as necessary. There are no guidelines for annual medical examinations. More detailed jurisdiction–specific minimum prisoner health care standards have been developed by individual States/Territories. For example, in Victoria in 1997, minimum prisoner health care standards were developed 'in areas where there is a need to ensure consistency between service providers', such as in optometric services, dental treatment and access to methadone programs.

References

Australian Bureau of Statistics (ABS) 1999. Prisoners in Australia: a report prepared for the Corrective Services Ministers' Council. Canberra: ABS.

ABS 2000. Corrective Services, Cat. No. 4512. Canberra: ABS.

Australian Institute of Health and Welfare (AIHW) 1999a: Moon L, Meyer P & Grau J. Australia's youth—their health and wellbeing 1999. Canberra: AIHW.

AIHW 1999b. Australia's welfare 1999: services and assistance. Canberra: AIHW.

AIHW 2000a. National health data dictionary. Version 9. Canberra: AIHW.

AIHW 2000b. Australia's health 2000: the seventh biennial report of the Australian Institute of Health and Welfare. Canberra: AIHW.

AIHW 2001. National health data dictionary. Version 10. Canberra: AIHW.

Britt H, Sayer GP, Miller GC, Charles J, Scahill S, Horn F, Bhasale A & McGeechan K 1999. General practice activity in Australia 1998–99. AIHW Cat. No. GEP 2. Canberra: AIHW (General Practice Series No. 2).

Butler T 1997. Preliminary findings from the inmate health survey of the inmate population in the New South Wales correctional system. Sydney: Corrections Health Service.

Butler T, Dolan K, Ferson M, McGuinness L, Brown P & Robertson P 1997. Hepatitis B and C in New South Wales prisons: prevalence and risk factors. Medical Journal of Australia 166: 127–30.

Crofts N, Stewart, Hearne P, Yi Ping Xin, Breschkin A, & Locarnini S 1995.Spread of bloodborne viruses among Australian prison entrants. British Medical Journal 310:285–8.

Conference of Correctional Administrators 1996. Standard guidelines for corrections in Australia 1996. Brisbane: Conference of Correctional Administrators.

Dalton V 1998. Australian Deaths in Custody and Custody-related Police Operations 1997–98. Canberra: Australian Institute of Criminology.

Dalton V 2000. Australian Deaths in Custody and Custody-related Police Operations 1999. Canberra: Australian Institute of Criminology.

Dolan K 2000. The epidemiology of hepatitis C infection in prison populations in the Commonwealth of Australia. Hepatitis C—informing Australia's national response. Canberra: Commonwealth of Australia.

National Centre in HIV Epidemiology and Clinical Research 2000. HIV/AIDS, Hepatitis C and sexually transmissible infections in Australia, annual surveillance report. Sydney: National Centre in HIV Epidemiology and Clinical Research, the University of New South Wales.

New South Wales Law Reform Commission 1994. People with an intellectual disability and the criminal justice system: courts and sentencing issues. Discussion paper 35. Sydney: New South Wales Law Reform Commission.

Royal Commission into Aboriginal Deaths in Custody 1991. Final report of the Royal Commission into Aboriginal deaths in custody. Canberra: Commonwealth of Australia.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2001. Report on Government Services 2001. Canberra: Commonwealth of Australia.