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Kathryn M. Weston
University of Wollongong, kathw@uow.edu.au


Louella R. McCarthy
University of Wollongong, louella@uow.edu.au

Isobelle Barrett Meyering
Macquarie University, University of Wollongong

Stephen Hampton
Justice Health & Forensic Mental Health Network

Tobias Mackinnon
Justice Health & Forensic Mental Health Network

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Abstract

The value of history is, indeed, not scientific but moral ... it prepares us to live more humanely in the present, and to meet rather than to foretell, the future - Carl Becker. Becker's quote reminds us of the importance of revealing and understanding historical practices in order to influence actions in the future. There are compelling reasons for uncovering this history, in particular to better inform government policy makers and health advocates, and to address the impacts of growing community expectations to 'make the punishment fit the crime'.

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Health behind bars: can exploring the history of prison health systems impact future policy?



Kathryn M. Weston^{a,*}, Louella R. McCarthy^a, Isobelle Barrett Meyering^a, Stephen Hampton^b, Tobias Mackinnon^b

^a School of Medicine, Faculty of Science, Medicine and Health, University of Wollongong, Wollongong, NSW 2522, Australia

^b Justice Health & Forensic Mental Health Network, PO Box 150, Matraville NSW 2036, Australia

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ABSTRACT

The value of history is, indeed, not scientific but moral ... it prepares us to live more humanely in the present, and to meet rather than to foretell, the future - Carl Becker.

Becker's quote reminds us of the importance of revealing and understanding historical practices in order to influence actions in the future. There are compelling reasons for uncovering this history, in particular to better inform government policy makers and health advocates, and to address the impacts of growing community expectations to 'make the punishment fit the crime'.

The current prison population of Australia is at an all-time high with over 40,000 adults currently in full-time custody² – and over 5000 young people (aged 10 and older) under youth justice supervision.³ NSW has the largest prison population of any Australian state, with almost one-third (32%) of all Australian prisoners being held in NSW jails.² There are strong indicators that these numbers are likely to climb.⁴ In the 230 years since the penal colony of New South Wales (NSW) was established, the state has overseen, and, for most of this time, operated the prison system. Throughout the period, the 'incarcerates' have been drawn primarily from the most disadvantaged in our society and those with some of the highest health needs; in the first quarter of 2017, Aboriginal and Torres Strait Islander people accounted for over one-quarter (28%) of all adult prisoners despite representing just 2% of the population.² A focus on NSW as a case study of the medical history of incarceration may reveal important perspectives on health of the prison population in relation to the philosophy behind incarceration and community expectations of punitive measures.

The health status of prison populations is often poor for a variety of reasons.⁵ One of the overriding reasons is that prisoners often represent a 'multi-dimensionally disadvantaged' group. As many prisoners tend to be 'non-help seekers' or those who find accessing the health system difficult, the prison environment may be the first place where they access health care services. Effective health care delivered in prison may provide great benefits not just for those imprisoned, but also to the community with benefits from the reduction in overall morbidity and

also from potential reductions in rates of re-offending.⁶

Prison healthcare needs and delivery have changed over time in response to changing disease patterns, societal attitudes and political forces, and effective public policy relating to the healthcare of prisoners exists at both a state and federal level. However, little is known about the historical development of such policies and the drivers for change over time, areas which are fundamentally implicated in the health outcomes for prisoners. Equally significant is the connection between prison health services and public health systems more broadly. Examining these areas and the historical relationship between policy and health creates opportunities for new answers to old questions. It is possible that better historical understanding can contribute to both enhanced models for health care, and improvements in the health of the incarcerated.¹

The historical material documenting the provision of healthcare in NSW gaols over the past 200 years is both extensive and selective. Nevertheless, these records reveal practices in prisons which reflect social attitudes to prisoners and beliefs about social relations, and held implications for prisoners' health and healthcare over time. While early documents such as the 1822 Bigge Report recognised the significance of both physical and mental health issues of convicts,⁷ solitary confinement (Berrima Gaol), hard labour (Albury Gaol), systematic starvation (Darlinghurst Gaol) and 'sadistic' beatings (Grafton) all illustrate contempt for prisoners and their health. This disregard was not confined to 19th century prisons: poor, dirty conditions in Bathurst Gaol were

* Corresponding author.

E-mail addresses: kathw@uow.edu.au (K.M. Weston), louella@uow.edu.au (L.R. McCarthy), i.barrettmeyering@unsw.edu.au (I.B. Meyering), Stephen.Hampton@justicehealth.nsw.gov.au (S. Hampton), Tobias.Mackinnon@justicehealth.nsw.gov.au (T. Mackinnon).

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found to have ignited severe riots in 1974,⁸ which in turn led to deep questioning about the status of prisoners and their custodians in our society. These examples highlight the tension between the requirements of a prison (involving control, confinement, and punishment) and a medical ethos that pledges to put the interests of the patient first. This tension continues to influence prison medical practice around the world.

One way of investigating the philosophy of service delivery and how that philosophy has informed policy and models of care is by tracing its influences in colonial, and later state, legislation. The colony of NSW was wholly governed by Britain until 1823, when limited autonomy was granted. One of the first pieces of local legislation passed concerned the location for housing prisoners – those who committed crimes in the colony, not those transported for doing so.⁹ In 1840, NSW legislated its own Act for Regulating Gaols, Prisons, and Houses of Corrections,¹⁰ having deemed the British legislation, ‘not applicable to the Colony of New South Wales.’ At this point the position with authority over all prisons was the Sheriff, under the direction of the Colonial Governor, whose responsibilities included custody of the prisoners and staff appointments. This legislation laid out clear directions for the health and safety of inmates, and provision of a prison infirmary or hospital was included in the rules. Thus, it was required that there be:

‘... a convenient and suitable apartment, within the gaol, ... set apart and appropriated as an Infirmary for the reception of sick and diseased prisoners, and a separate one for females.’¹⁰

The Act went further, stipulating the cleanliness and ventilation required for all prisons, as well as the necessary ‘air’ and exercise prisoners were to be afforded ‘for the preservation of health’. This had spatial implications, as ‘places for such shall be allotted for the different classes respectively as circumstances will permit.’ Equally significant, the duties of the prison surgeons were spelled out. The hitherto relatively autonomous surgeons now needed to keep a journal, to enter ‘day-by-day, and in the English language an account of the state of each sick prisoner, the name of his or her disease, a description of the medicine and diet, and any other treatment he may order for each prisoner.’ The 1867 Regulations to this Act clarified even further the roles and requirements of the medical personnel associated with prisons.

In 1874 the Prisons Act (37 Vic. Act No.14) realigned the authority structure by the creation of the position of Comptroller General of Prisons responsible for the management of all prisons within the colony and the custody of all prisoners.¹¹ This legislation represented a move towards greater uniformity in the prison system. Throughout this period of legislative change there were ongoing discussions of prison reform, including how this related to the physical and mental health of prisoners. The Prisons Act 1899 (Act No.27) consolidated existing Acts concerning the regulation and control of prisons and the custody of prisoners.¹² It specifically addressed the health of prisoners and included provisions on who was responsible and employed through the prison system for the care and safety of prisoners; on the health of the prisoner as related to the provisions of the cell, surgeon’s advice and exercise; and on the removal of prisoners due to contagious diseases. This Act remained in force until 1952 when the Comptroller General’s position became located within the portfolio of the Minister for Justice.

Particularly rich sources of information are the many public inquiries into the service. One of the earliest of the formal inquiries was chaired by the Hon. Henry Parkes and reported in 1861.¹³ The Committee took:

‘evidence of a large number of persons, including many inmates of the several prison ... It appears to the Committee necessary especially to notice the revolting character of some of the evidence received; its very enormity is submitted in justification of its publication ...’

The historical voice of prisoners collected during the Parkes Inquiry

is a rare piece of evidence. This same source also provides glimpses into the living conditions of those in custody:

‘On Cockatoo Island: There are five dormitories, which have been built with very imperfect means of ventilation; on either side of each there are double tiers of transverse sleeping berths, with coffin-like apertures opening upon a narrow central passage. In this passage are placed night-tubs for the common use of the men during the twelve hours they are locked up. Two of the dormitories contain 88 berths each, and one contains 48; in all there are 328 berths of the character described ... [Mr Inspector Lane] says he has often seen them [the men] at the iron gratings gasping for fresh air from without, and he “wonders how they live”.’¹³

While Cockatoo Island was admitted to be the worst example of prison then operating in the Colony, even the new, modern Darlinghurst prison was deemed to be filthy and bug infested:

‘... vermin in many of the cells, in the female cells, particularly, the common house bug was in masses of hundreds forming dark patches on the walls.’¹³

It must be kept in mind that, in addition to the numerous formally constituted inquiries exemplified above, were myriad internal investigations following up prisoner complaints and other allegations involving specific gaols and particular events. Examples include the inquiry into the supply of bread for Newcastle’s prison hospital in 1835,¹⁴ and into prisoner complaints of their doctor in Maitland in 1883.¹⁵

Identifying how the delivery of health care in prisons is a result of historical forces as well as medical science and political debates will enable a better appreciation of current practice and future needs. Research is continuing to further identify the key events, people and philosophies which have contributed to the development of prisons health services in NSW. Despite (or perhaps because of) Australia’s long and intimate historical relationship with the penal system, attitudes to prisoners remain one of entrenched aversion. A step towards ‘de-othering’ prisoners lies in a greater familiarity with our shared history, involving both the institutional and the individual experiences of the incarcerated. Exploring the history of care for one very disadvantaged group may also influence our understanding of the care of other similarly disadvantaged ‘othered’ groups, whether Aboriginal and Torres Strait Islander people, people with a disability, migrants, or asylum seekers.

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