

I visited long bay  
hospital in matrville,  
sydney



**ASSIGN  
BUSTER**

I visited Long Bay Hospital in Matraville, Sydney, on the morning of Tuesday, May 1st. As the hospital is located within the grounds of Long Bay Correctional Complex, I had to pass through two separate security checkpoints- one at the main gate and the second at the entrance to the hospital. Immediately, one become aware of the unique milieu- that Long Bay Hospital would be unlike any other public psychiatric unit. Despite nominally being a hospital, the facility is predominantly a prison. My visit was centered on ward D of the hospital, which is an acute psychiatric unit.

There, I participated in a ward round/case conference with some patients, the duty psychiatrist and one of the nurses. Six patients were interviewed during the conference, with the general focus being a review of each patient's clinical progress. However, we did have some opportunity to obtain a brief history from most of the patients, regarding their past and current symptoms, some social and personal history, as well as their forensic issues. I was also able to take a short tour around the hospital, and inspect some of the rooms/cells, part of the outdoor areas available to inmates, and the security measures undertaken. In addition, I also conversed with some of the staff members present, including the duty psychiatrist, some of the nursing staff and one custodial officer, regarding their roles and duties, as well as hospital administration, procedures, services and treatment programs available. We also discussed issues relevant to forensic psychiatry in general, the difficulties and shortcomings of existing prison psychiatric services and possible future changes.

Long Bay Hospital- An Overview  
The Environment  
Long Bay Hospital is a 120-bed facility, comprising of four wards A, B C and D, with 30 beds in each

<https://assignbuster.com/i-visited-long-bay-hospital-in-matraville-sydney/>

ward. Currently, wards A, C and D are designated psychiatric units, with ward B being a general medical ward. Ward D, which is the focus of my visit, was filled to maximum capacity, housing 28 patients, with the remaining two being seclusion rooms. There was even some mention of a waiting list by the duty psychiatrist, highlighting the sheer burden of the hospital.

As mentioned before, Long Bay Hospital is very much predominated by prison culture, with little resemblance even to the secured environment of a psychiatric hospital. Guard towers are clearly visible from the hospital grounds, and security measures are more typical of that in a prison than in a psychiatric unit. Of course, given the location of the facility, this is not at all surprising. The interior is also unwelcoming.

The patients' rooms resemble cells more than bedrooms, with heavy metal doors that lock externally, and basic facilities within. There is little privacy, in particular in the close-observation rooms, where patients who are at risk of suicide or deliberate self-harm are placed. These rooms are under twenty-four-hour close-circuit video monitoring, and are quite bare, almost stark, with no television, radio books, magazines, or any other form of daytime occupation except for a pack of playing cards for the inmate. The Patients: Distribution and Demographics At the time of my visit, the ward D is mostly serving patients who are acutely psychotic or recovering from acute psychosis. Of the six patients seen in the ward round/case conference, all demonstrated symptoms of schizophrenia. Several have dual diagnoses, most commonly being substance abuse.

One patient has concurrent paranoid and antisocial personality disorders. The patients in the psychiatric hospital are relatively young, usually aged in their 20's and 30's, in contrast to facilities in the community, which admits a significant number of middle-aged to elderly patients with chronic/refractory mental illness. All patients seen during the visit have significant psychosocial problems. All had experienced some kind of family dysfunction in childhood, ranging from family breakdown to abuse.

They had limited education and scanty employment histories. All are repeat offenders, having committed crimes ranging from misdemeanors and minor offenses such as breach of parole, to acts of violence such as aggravated assault and armed robbery. The other wards were not visited. However, it was explained the ward C held a similar mixture of patients, although they tend to be of a more subacute type. Ward A mainly provides for forensic patients. These which include those who are detained while their fitness to stand trial is ascertained, those who are found unfit to be tried, those found not guilty by reason of insanity and prisoners who've been transferred to the hospital under legislative provision by reason of mental illness [1].

The Staff There are five doctors working in the hospital, and in the morning of my visit, six nurses were on duty in ward D- with probably similar numbers in the other two wards. This medical team and their support staff are responsible for the daily care of the patients, as well as performing court-ordered psychiatric assessments. In addition, there are six corrective services officers assigned to ward D. They are security personnel with no knowledge of issues regarding psychiatric patients- their education is in physical training, conflict resolution and relevant laws. Although some of the

<https://assignbuster.com/i-visited-long-bay-hospital-in-matraville-sydney/>

younger officers tend to be more liberal, most of the senior staff originates from the culture of a hostile occupation, and their attitudes tend to reflect this. Read which one of these does not pose a risk to security at a government facility

### Psychiatric Admissions

The ninety patients in the psychiatric unit in Long Bay Hospital come from many different prisons across New South Wales, including remand centers such as Silverwater, and regional facilities such as Grafton and Junee.

### Intake and Assessment

Most of the patients admitted for episodes of psychosis have been assessed by a duty psychiatrist or a crisis team at their “ home” prisons, and on this basis, have been transferred to Long Bay Hospital for further evaluation and treatment. This procedure is similar to that in the community, where a GP, a case manager or a carer may refer a psychotic individual to an inpatient facility for urgent intervention. Upon arrival, the prisoner is assessed as they would be in any other psychiatric hospital. However, the performance of a proper assessment may be constrained by time, inadequate trained personnel and security demands.

Patients may also be uncooperative, more guarded and mistrustful than in a general psychiatric hospital, due to their situation. As well, they tend to focus on how their symptoms, treatment and outcome affect their legal predicament, rather than on the illness process itself. For example, a patient who was interviewed during the visit made repeated references to his likelihood of parole in relation to his compliance to treatment. In the case of a court-ordered psychiatric assessment for remand prisoners, who may have no or a scattered medical history, there is the added difficulty of trying to obtain corroborative documents or interviews with relevant third parties.

Arrangements for special investigations such as neurological imaging may be hampered by security issues [2].

Admission Patients are admitted under similar criteria as that in a general psychiatric hospital. Most of the patients admitted into Long Bay Hospital suffer from some form of psychosis, usually schizophrenic psychotic episodes, but some may have mania. Major depression, suicidal ideation and repeated self-harm are also grounds for admission. In the past, patients may gain admission into the hospital and hence temporarily “ escape the prison environment” by an act of deliberate self-harm.

This can no longer occur, due to a growing population of prisoners with mental illness and limited resources. Some patients may have little or no insight into their psychotic symptoms, and refuse to comply with treatment. In this case, they may then be compelled to receive medication as provided by the Mental Health Act, as they would be in the community. As the facility is mainly an acute and subacute unit, the mainstay of management is pharmacotherapy, and the medications used are the same as those in a general psychiatric hospital.

However, there are a higher proportion of patients in Long Bay Hospital who are receiving their drugs in the form of depots, due to their agitated behavior and noncompliance issues. Discharge Regular reviews and consultations are held for each patient, in order to monitor illness progression and to assess the possibility of discharge. The decision for discharge is based on the same principle as those for any other patient with a chronic mental illness- their capacity to function outside the hospital environment. Upon discharge, most

psychiatric patients in Long Bay Hospital are returned to their “ home” prisons, where they are followed up by the resident psychiatric clinic. Some are transferred to the Kestrel Unit at Morrisset Hospital, a maximum-security unit designed to serve forensic patients. The rest are released from remand, or at the expiry of their sentence [3].

A Clinical Vignette Daniel is a thirty-year-old Caucasian man who was transferred from Junee prison to Long Bay Hospital for the treatment of an acute psychotic episode, when he suffered from paranoid delusions. He is a chronic schizophrenic who suffers from auditory hallucinations which he believes is the “ voice of God”. Although unproven, it is likely that, during one such hallucinatory episode, he committed his latest crimes- two counts of aggravated (sexual) assaults on two young girls. According to Daniel, the “ voice of God” had made him believe that what he did was “ all right”. Daniel was convicted and sentenced to four years imprisonment, with a minimum non-parole period of two years.

Currently, he has twelve months remaining of his total sentence. His main management in Long Bay Hospital consists of risperidone, which had produced marked improvement of his symptoms. However, despite his compliance with his medications, his insight is still impaired, and his religious delusions fail to abate. During the interview, Daniel showed the typical blunted affect of a schizophrenic patient.

He was also extremely guarded, especially when questioned on his past symptoms. However, he was willing to discuss his legal issues, especially his experience with the Parole Board, which denied his application for parole,

due to his “ noncompliance” with treatment- he’d refused to participate in a Relapse Prevention program, which the Board considers to be an indicator of rehabilitation. As a result, he is now serving time that is beyond his non-parole period. Issues regarding Daniel’s discharge were also discussed. His treating psychiatrist believes that his current mental state is “ as good as it’ll ever get”, and he is considered ready for transfer back to Junee prison, where he will be followed up by the prison’s psychiatric outpatient clinic.

However, the continuity of care will become difficult after his release in a year, as Daniel has no fixed abode and little social support. Relevant

IssuesSeveral issues were raised from this clinical case and the ensuing discussion:<sup>\*</sup> Treatment and Rehabilitation of Mentally Ill Violent

OffendersThe NSW Department of Corrective Services employs over 75 psychologists, who are responsible in providing psychological rehabilitation to inmates, through Relapse Prevention and other psychotherapies. Relapse Prevention is a variant of cognitive behavioral therapy that aim to help the offender recognize the chain of events that typically lead to aggression and develop more adaptive ways to cope with these events, so that aggression may be circumvented. This approach differs from conventional psychotherapy, which attempt to modify the aggressive behavior itself [4].

Such a strategy may be effective for offenders with good insight into their behavior, but it is unlikely to produce any benefit for Daniel, or for any other mentally ill inmates with chronic delusions and impaired insight. These patients are not likely to be motivated to change, unless it is to use the program as a token effort to convince the Parole Board that they have “ addressed the factors underlying their offence”. More importantly, the

<https://assignbuster.com/i-visited-long-bay-hospital-in-matraville-sydney/>



management of the violent and mentally ill inmate needs to focus on eliciting the symptomatology underlying their aggression, which itself is a heterogeneous act, not a single treatable symptom [5]. Thus, in Daniel's case, where criminal violence is closely related to psychosis, it is more effective to treat the underlying causative factor (his hallucinations) than to focus on his aggressive behavior.\* Continuity of Care For an individual like Daniel, who has no fixed social base prior to his incarceration, continuity of psychiatric care is a significant problem.

Whilst he may be followed up in Junee prison's psychiatric clinic, this monitoring is not likely to continue over the long term after his release. At present, New South Wales has no organized plan to ensure the continuity of care of forensic psychiatric patients discharged into the community.

Although the staff at Long Bay Hospital do attempt in linking discharged patients with community mental health services, especially those who are involved with some community-based treatment programs before their incarceration, difficulties arise for patients with no such prior support. There is a view that ex-prisoners with mental illness are the responsibility of the corrective services system, which is separate from the community, thus preventing effective coordination of services [6]. In addition, many service providers, in particular general practitioners, are reluctant to accept ex-prisoners as clients. All this poses significant problems, because, without proper support to ensure medication compliance, there is a significant risk of breakdown, a return to psychosis and re-offence [1, 6].

Some models adopted overseas have shown to be effective in this aspect of psychiatric care. Some of these include the Care Program Approach in the <https://assignbuster.com/i-visited-long-bay-hospital-in-matraville-sydney/>

UK, the continuity of care plan recommended by the US National Association of Social Workers, and a similar strategy advocated by the Canadian Mental Health Association [6, 7, 8]. In these models, there is structured coordination between the prison medical system, community mental health providers and probation services to connect the client with post-release treatment and support. Such planning is initiated whilst the patient is still in the prison system to ensure a smooth transition; with the prison medical service providing some post-release care until the designated community service assumes full responsibility [6, 7].

Criticisms and Recommendations for Change  
Aside from continuity of care issues, there are some areas of the New South Wales forensic psychiatry service that should be the focus for change. The Hospital Environment  
As mentioned before, Long Bay Hospital is dominated by a prison culture. This seriously inhibit the development of a therapeutic alliance, and hence the provision of quality treatment and rehabilitation. The reason for this is the conflicting attitudes of the custodial staff and the health-care professionals. Whilst the former group is employed for the clear objective of providing security for the punishment of inmates, the latter hope to promote the health of the patients under their care.

In addition, these security demands also create inefficiency, as access to patients must comply with prison regulations. For example, on the morning of my visit, the inmates were “locked down” for an extra hour, as there was no duty custodial staff, who were all attending a meeting. Whilst this occurred, the treating psychiatrist was unable to interview any of his patients. In 1997, NSW Corrections Health Services commissioned UK  
<https://assignbuster.com/i-visited-long-bay-hospital-in-matraville-sydney/>

Professor Robert Bluglass to conduct the Review of Forensic Mental Health Services NSW.

The resultant report recommended the establishment of a stand-alone maximum-security psychiatric hospital, designed with a more therapeutic setting, similar to those seen in South Australia, Queensland and Victoria [1]. A stand-alone hospital can provide a much more effective therapeutic milieu. Access to patients would be more efficient, and treatment can occur in a less hostile environment. Properly trained staff who are experienced in dealing with psychiatric patients can replace the corrective service custodial officers. In addition, a new hospital can alleviate the overburdening of the existing Long Bay Hospital, which now only has 30 medical beds to serve the entire prison.

**Therapy and Rehabilitation**The Bluglass Report also raised the question of providing a multidisciplinary program for patients in Long Bay Hospital, with non-pharmacological approaches such as occupational therapy [1]. However, from my observations and from interviews with staff members, there is little indication that these recommendations have been implemented. Apart from a limited diversional therapy program which provide some art and cooking activities, most of the patients merely sat around, seemingly dispirited, with little to occupy them. This is unfortunate, since occupation opportunities can produce some improvement in motivation and mood, as is the case in Mulawa women's prison [1]. **The Way Forward**Although service provision in Long Bay Hospital continues to develop, and the state government continues to provide increasing funding for the facility, there is much that could still be improved. To their credit, the Corrective Health Services, in response to the <https://assignbuster.com/i-visited-long-bay-hospital-in-matraville-sydney/>

Bluglass Report, had established a working group of professional and independent persons to assess the feasibility of some of the recommendations in the report. Unfortunately, though, the most important proposal in the report- the establishment of a stand-alone maximum-security forensic psychiatric hospital- has not yet been considered, and the likelihood of it becoming a reality depends on fiscal decisions made by the New South Wales government.