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Tasmanian Government

Ms Ella Haddad MP
Chair
Standing Committee on Government Administration B
Via Email: assemblygab@parliament.tas.gov.au

14 MAY 2025

Dear Ms Haddad

Thank you for your letter of 24 March with further questions relating to ADHD treatment of prisoners within the Tasmania Prison Service, following my appearance at the Inquiry into the assessment and treatment of ADHD and support services. I apologise for the delay in this response.

Please find attached answers to the questions outlined in your correspondence.

Yours sincerely

Hon Madeleine Ogilvie MP
Minister for Corrections and Rehabilitation

Response to further questions from the *Standing Committee on Government Administration B* in relation to ADHD and support services available to prisoners in Tasmania

- *When people are first processed into Risdon Prison and they have a current prescription for any medications, is it standard practice for them to have those medications removed or discontinued upon entering prison?*
    - *If so, are all medications removed or discontinued, or only particular medications (e.g., stimulant medications or other medications of addiction)?*
    - *Whose decision is it for this removal or discontinuation to occur? (i.e. Tasmanian Prison Service staff or Correctional Primary Health staff)?*

Many of the medications commonly prescribed in the community (not just ADHD medications but also many others) are able to be misused (i.e., for recreational, non-therapeutic purposes), and therefore makes them desirable and trafficable. This presents a risk in various ways including the health risks caused by substance misuse; the risks that arise from an individual possessing a trafficable substance (such as the risk of standover to an individual where others become aware of the medication they have been prescribed); the risk of a prisoner needing medication, diverting it, and then not getting the benefit of it; and the dangers associated with drug trafficking such as increased levels of assault by prisoners misusing drugs or trying to control the drug trade.

While there are sound processes in place to reduce the capacity of prisoners to divert prescribed medication, prisoners can employ a number of strategies to limit the effectiveness of those processes.

Because of these risks, there are certain medications that are considered unsuitable for use in the prison. Where an individual is prescribed one of these medications and comes into custody, the Correctional Primary Health Service (CPHS) assesses the medication needs of that individual and prescribes them a suitable alternative medication where necessary. In many cases, prescriptions that are made prior to someone entering prison are maintained during their time in prison.

It is important to note that it is not uncommon for people to ‘doctor shop’ when in the community and consequently have prescriptions for medications that may not ordinarily be prescribed together, or in quantities that are unsafe. When a prisoner has their medications reviewed by a CPHS doctor, their prescriptions may change based on a more complete medical picture or based on the suitability of certain medications within the prison. It is also not uncommon for people entering into custody to be taking increased dosages of medications outside of the prescribed amount, which means that when they enter an environment where their prescription level is controlled at the correct level; this constitutes a change in their medication regime from what they had been taking.

All prescription decisions are made by the CPHS, not the Tasmania Prison Service.

- *Is the same process followed for the reception prisons (Hobart, Launceston and the Southern Remand Centre) regarding medications being removed or discontinued on processing?*

Yes, remandees are also subject to review by CPHS and medications that are not considered suitable for a prison environment would also not be considered suitable for those on remand.

Prescriptions are not changed prior to assessment by the Correctional Primary Health Service.

In reception prisons, particularly where prisoners are remanded over a weekend, if the CPHS has been unable to review or access prescribed medications, as a last resort family can bring in labelled and sealed prescribed medications with a copy of the prescription for someone on remand which is then provided to CPHS, to ensure the prisoner continues to have access to appropriate medication up until the point they have been reviewed by a CPHS doctor.

- *How long is the average wait for someone who has entered the prison system and had medications removed or discontinued to see a prison doctor, psychologist or psychiatrist when required?*

Medications are not removed before a prisoner or remandee has been reviewed by a doctor.

Every prisoner is assessed through a process called the tier 1 assessment. This assessment determines the immediate management needs of each individual coming into custody, including suicide and self-harm (SASH), protection and association issues, issues of vulnerability and other matters that may impact on the safe placement of that person in custody. These factors are all assessed within two hours of reception into custody. As part of this assessment new receptions into custody are asked if they have any medical concerns and if critical medical concerns such as the requirement for a certain medication in a short time period is flagged this is immediately referred to CPHS or if required, the new reception may be transported to hospital. Outside of the formal tier 1 assessment process, people in custody have access to an intercom in each cell and are able to speak with staff at any point if they have any medical concerns.

The tier 1 assessment also includes an initial health assessment by the Correctional Primary Health Service which needs to be completed within the 48-hour time frame.

A more comprehensive health review then takes place as soon as practical.

Where a need for support from Counsellors or Psychologists is identified as part of the tier 1 assessment process referrals are made. Where there is concern about an immediate risk of SASH, the person is seen immediately. Individuals presenting with complex needs are also seen quickly. Outside of immediate risk and complex needs, people are generally seen between 1 and 2 weeks of the referral.

- *Do these medical appointments happen automatically if someone has had a regular prescribed medication removed or discontinued, or do prisoners have to specifically request such an appointment?*

All prisoners have a medical assessment as part of their reception into prison including a review of their prescribed medications.

- *What if any are the routine ways that TPS and Correctional Primary Health staff communicate when a prisoner has apparent health issues*?

TPS and Correctional Primary Health Staff work closely together on a daily basis. Health clinics occur within prison facilities and information is shared as required/appropriate. Health related matters are managed by CPHS, who provide treatment in TPS facilities or may recommend that prisoners are transferred to hospital for further treatment.

TPS and CPHS staff also work closely together in managing high risk prisoners such as where suicide and self-harm risks are present.

- *How many prisoners have been diagnosed with ADHD whilst within the prison system?*

The TPS does not record this information. Nationally, it is estimated that up to 40% of prisoners have ADHD.

- *Noting answers given during the hearing stated that no prisoners have access to stimulant based ADHD medications:*
    - *What's the total number of prisoners who have ADHD?*

As per above response, the TPS does not record this information.

    - *Of that total number, how many are given access to non-stimulant ADHD medication such as Atomoxetine?*

There are currently less than 25 prisoners prescribed medications that can be used to treat ADHD. Some of this group may be taking this medication for a purpose other than ADHD treatment.

    - *Of that number, how many are provided with other supports, such as behavioural therapy*?

Any prisoner exhibiting difficulties coping in prison or experiencing other challenges is provided therapeutic supports. These include brief interventions, Cognitive Behaviour Therapy, Dialectical Behaviour Therapy and Acceptance and Commitment Therapy. The TPS does not have a specific ADHD with treatment modality.

    - *Are there any statistics or advice regarding the effectiveness of these treatments in treating symptoms of prisoners with ADHD*?

There are significant amounts of research publicly available regarding effective treatment for ADHD. Gold standard treatment is generally considered therapy and medication combined. However, behavioural interventions on their own also provide benefit.

- *Is any consideration being given as to how stimulant medication that is necessary for people with ADHD can be made available to prisoners in a way that mitigates risk of misuse or diversion? If not, is there scope to consider this in the future?*

This is not currently under consideration. As new medications become available, however, their use will be considered. A good example of this within the prison has been the change in the way that the Opioid Pharmacotherapy Program is delivered in the prison, with a move away from buprenorphine strips which were able to be trafficked in the prison and presented challenges, to now largely using Buvidal depot injections which are long lasting and less easily trafficked.

- *In response to questions regarding liquid forms of stimulant medication, and the viability of prescribing stimulant medications in liquid form to prevent diversion, answers were given of instances of prisoners vomiting up ingested fluid to distribute.*
    - *How common are incidents where liquid medication has been diverted such as was described in answers during the hearing? How many instances have been recorded in the past 12 months?*

The TPS does not keep a record of incidents such as these with the level of detail that would be required to extract accurate figures.

- *What measures exist to mitigate this from occurring?*

When medications are given to prisoners they are required to demonstrate that they have swallowed the medication. Where there are reports that a prisoner is diverting their medication (through any means) the TPS monitors that prisoner more closely through various mechanisms to reduce the risk of medications being diverted and they may have their medication changed or be removed from the Opioid Pharmacotherapy Program.

- *During answers to questions in the hearing, it was stated that diagnosis and treatment of prisoners for ADHD can cost upwards of $3000 per prisoner. Given the known correlation between untreated ADHD and increased impulsive and criminal behaviour, is there any understanding of the financial cost to the correction system in not treating these symptoms, and increased risk of impulsive and antisocial behaviour within prisons, as well as increased risk of recidivism? Would the cost of not providing such support amount to more, or less than the $3000 figure stated to assess and treat prisoners?*

This question makes some broad assumptions and is asking for conclusions to be drawn around the impact of ADHD in a very complex system and complex factor such as recidivism.

It is recognised that treatment in prison may result in better outcomes while the person is in prison, but this does not necessarily correlate with ongoing positive outcomes to the person once released. There are many barriers for an individual once released specifically in relation to their ADHD treatment such as accessing specialists, affordability of medications, maintaining the correct dosage of medication as well as other factors which may not be related to ADHD but which impact recidivism such as addiction, homelessness, poverty, trauma, brain injuries, other diagnoses and lifestyle choices.

The multifactorial nature of the majority of prisoners' lives means that it is difficult to accurately isolate a single factor and predict the impact of that factor.

This is a growing field of research and one that cannot be adequately addressed in this response.