who are more susceptible than men to being over-medicalised in prison, are overlooked. Significantly, the Draft states that 'prison medical officers should be mindful of the needs of departments of corrective services'. This raises the issue of whether prisoners' rights or the needs of the department will prevail in instances where they are in conflict.

Concerned prison watchers might contemplate the broader issue of whether private prisons are breaching international instruments such as the Convention Against Torture and Other Cruel and Degrading Treatment or, more crucially, the International Covenant on Civil and Political Rights which includes the right to freedom from torture and cruel, inhuman or degrading treatment or punishment and is given legislative force throughout Australia by the Commonwealth's *Human Rights and Equal Opportunity Commission Act 1986*. More immediately relevant to the question of health services to prisons, is clause 62 of the United Nations 'Standard Minimum Rules for the Treatment of Prisoners'. This clause states:

> The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.

International forums are avenues of last resort. The Ombudsman and Health Commissioner's offices are not. The outcomes of their investigations into health services at MWCC are awaited with interest. In the meantime, all that can be said is that without public access to the MWCC's health services contract, it cannot be known what they are contractually bound to provide. It would appear, however, that all is not well with health services to the women's prison in Deer Park.

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3. *Herald Sun*, 6 November 1996; *Herald Sun*, 15 November 1996.
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9. *Age*, 12 April 1997.
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SUPPORTED RESIDENTIAL SERVICES

Reviewing the adequacy of medical services

JANE FYFIELD and DAVID REECE **examine the process and issues to date in a recent government review.**

The Department of Human Services commissioned a *Review of the Adequacy of Medical Services to Residents in Supported Residential Services (SRS)* in August 1998.

What is an SRS?

An SRS is defined in the *Health Services Act 1988* (Vic.) as premises where accommodation and special or personal care are provided or offered (other than for members of the family of the proprietor of the premises) for fee or reward but does not include a hostel. Currently there are 260 SRSs in Victoria caring for approximately 6500 residents.

SRSs are generally run as small businesses with income being generated solely from the fees paid by residents. Unlike nursing homes and hostels, which are funded and regulated by the Commonwealth Government, SRSs do not attract any external funding. They are required to be registered with the Victorian Department of Human Services and to operate in accordance with the provisions of the Act and Health Services (Residential Care) Regulations 1991. SRSs fall into three broad financial categories: those at the upper end of the market, those in the middle range and those which charge fees equal to or less than the age pension.

The SRS buildings are either converted houses or purpose-built facilities. The older ones often cater for the pensioner market and the purpose-built facilities for non-pensioners.

The SRS industry

People living in SRSs generally fall into two main groups according to their predominant medical condition with considerable overlap between them. The conditions indicate the care needs of the residents. The two groups are younger people with psychiatric impairment, intellectual disability and/or acquired brain injury and older frail people with personal care needs. Some of the residents of these facilities came from state run institutional care that is no longer available. Others have been homeless or have had very insecure housing for some time prior to obtaining

SRS accommodation. SRSs, for these Victorians, offer an important option in housing and care when choice is severely limited.

The SRS industry has a low profile in the community and residents in the lower end of the market find it difficult to access services like Home and Community Care (HACC) services. Barriers such as social isolation, few family networks and poverty limit the residents' ability to achieve good quality care for themselves.

Staff of SRSs are largely untrained carers although many do have some nursing background. This has led to discrepancies in care between facilities and difficulties for external providers of care, like medical practitioners and others, in knowing what level of care to expect from an SRS. Currently there is no requirement to have trained staff in SRSs but the regulations provide for a minimum ratio (1:30) of staff to residents. A report has been prepared for the Minister for Health and the Minister for Aged Care recommending a minimum qualification for a key staff member in each SRS.

The Review

The purpose of this Review is to determine whether residents of SRSs are receiving appropriate quality medical services, have their own choice of medical practitioner and have an informed choice of appropriate treatment.

Healthcare International, an independent consulting company, has been conducting the Review which is due to report at the end of November 1998. It reports to a Steering Committee which consists of personnel representing numerous sections of the Aged, Community and Mental Health Division of the Department of Human Services as well as the Health Services Commissioner, the Public Advocate and the President of the Association of Supportive Care Homes (the peak industry body). This committee will decide on the distribution of the final report and subsequent actions to be taken on the recommendations issuing from the report.

The methodology for conducting the review has included a literature review, a survey of the proprietors of SRSs, extensive interviewing of residents and staff, consultations with medical bodies, structured interviews with individual doctors, other health care providers, community services workers and other interested people. There have also been consultations with the industry peak body, the Health Services Commissioner, the Public Advocate, the Community Visitors Board and Department of Human Services regional and central office staff. Wide publicity has been sought through the newsletters of the industry peak body and the Divisions of General Practice.

There has been general support of the Review within the industry and from stakeholders. Many Divisions of General Practice have expressed an interest in a structured approach to an ongoing involvement aimed at improving the medical services offered to residents of SRSs.

Emerging issues from the Review include a combination of structural, systemic and process problems from within and outside the immediate industry. Many problems relate to the socially marginalised and disempowered groups and individuals the industry strives to serve. Other issues identify concerns with lack of education and fragmentation and the apparent complexity and inaccessibility of health and community services.

The Review will endeavour to identify issues that can be addressed in a systematic and cost effective way to improve the quality of life of the residents of supported residential services.

The Review will be presented to the Department of Human Services through the Steering Committee on 30 November 1998. It is the expectation of the Steering Committee that the Review will be published. Publication, distribution of the final report and action on the recommendations within the report will be at discretion of the Department.

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PROFESSIONALS

Sexual abuse by lawyers

BILL GLASER discusses sexual exploitation by professionals of their clients specifically comparing the law and health disciplines.

One of the standard jokes about legal ethics is that you can murder the client but you cannot run away with the trust funds. This certainly seems to apply to sexual relationships between lawyers and clients. In Australia, with the notable exception of the Family Court jurisdiction, there appears to be little or no disapproval of a legal practitioner who engages in sexual activity with even the most vulnerable client, provided that criminal or sexual harassment laws are not infringed. At a recent meeting of the Australian and New Zealand Association for Psychiatry Psychology and Law, the chairperson of the Victorian Bar Council Ethics Committee remarked that, during a period of several years he had encountered only one case of alleged sexual misconduct.

Sexual abuse by health practitioners

Sexual abuse by health practitioners, by contrast, is recognised as being both common and harmful. Between 7–10% of male mental health therapists and 1–3% of female therapists sexually abuse their clients. The perpetrators themselves are often experienced and well-respected members of professions such as medicine and psychology; to add insult to injury, they may compound their hypocritical claims that sex is 'therapy' by charging fees to the patient or third party such as Medicare. The victims themselves are usually intensely vulnerable. Many have experienced sexual and physical abuse in childhood and the effects of therapist abuse can often be devastating. Not only do victims receive inadequate or inappropriate treatment for the problems for which they first sought help, they also encounter disbelief and denial when they complain about their abuse to subsequent therapists or investigating authorities.[1]

The societal response to health professional abuse, although somewhat tardy, has nevertheless been significant.