NSW GOVERNMENT | Inspector of Custodial Services

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Health services in NSW correctional facilities

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Foreword

The provision of health services to inmates in New South Wales (NSW) custodial facilities is a complex and challenging responsibility. This is due to a combination of the size of the NSW correctional system, the need to deliver these services in a secure environment and a patient group with frequently complicated medical histories and co-occurring medical conditions.

Challenges to delivering health services in custodial settings have been previously identified in public reports. The 2015 Inspector of Custodial Services (ICS) report *Full House* noted the impact of rising prisoner numbers on the adequacy of health staffing, infrastructure and access hours.[1] Also published in 2015, the ICS report *Old and Inside* identified the challenge of meeting the complex healthcare needs of an increasing ageing population in an environment already strained of resources.[2] The 2018 ICS report *Inspection of 24-hour court cells in NSW* identified that these complexes are where the majority of inmates first enter custody and therefore it is crucial for health services to be provided at all 24-hour court cell complexes.[3] The *Residential Facilities and the compulsory drug treatment correctional centre* report discussed the provision of health services at these custodial centres.[4] The *Women on Remand* report considered the particular health needs of women in custody.[5]

In this context, it is perhaps unsurprising that consistently across 2016–17, 2017–18, 2018–19 and 2019–20, medical issues were the largest category of complaints made by inmates to Official Visitors.[6] In my 2016–17 Annual Report I observed that access to health services was a particular concern among adult inmates and, consequently, my office would commence an inspection examining the accessibility of health services for inmates in the first half of 2018.[7] Since then a NSW Parliamentary Inquiry has found Justice Health and Forensic Mental Health Network (JH&FMHN) to be under-resourced to meet demand, particularly in relation to mental health needs.[8]

Following the on-site component of this inspection which took place in 2018, data was requested, provided and analysed to allow a comprehensive understanding of the complexity of delivering custodial health services in NSW. Further follow up visits to correctional facilities took place in 2019.

As this report was nearing completion, the COVID-19 pandemic presented a new and unprecedented risk to the health of inmates, as well as that of the staff working in NSW correctional centres. From the outset, it was widely recognised that COVID-19 could quickly spread within correctional centres, and therefore among a population more likely to have health conditions that make them susceptible to developing a serious COVID-19 infection.

Since February 2020, I have liaised closely with Corrective Services NSW (CSNSW) and the JH&FMHN on their response to COVID-19 and from May 2020 my office commenced a series of visits focused on monitoring the implementation of this response in practice. To their credit, I have observed CSNSW and JH&FMHN working collaboratively and constructively on this response, the benefit of which was evident in

1 See Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population in NSW' (Report, April 2015) 49-59.

2 Inspector of Custodial Services (NSW), *Old and Inside: Managing Aged Offenders in Custody* (Report, September 2015) 50.

3 Inspector of Custodial Services (NSW), 'Inspection of 24-hour Court Cells in NSW' (Report, June 2018), 8-10.

4 Inspector of Custodial Services (NSW), '*Residential Facilities and the compulsory drug treatment correctional centre*' (Report, February 2020).

5 Inspector of Custodial Services (NSW), 'Women on Remand' (Report, February 2020).

6 Inspector of Custodial Services, *Annual Report 2016–17* (2017) 12–13; Inspector of Custodial Services, *Annual Report 2017–18* (2018) 16–17; Inspector of Custodial Services, *Annual Report 2018–19* (2019) 14–15; Inspector of Custodial Services, *Annual Report 2019–20* (2020) 17–18.

7 Inspector of Custodial Services, *Annual Report 2016–17* (2017) 20.

8 See Legislative Council Portfolio Committee No. 4: Legal Affairs, Parliament of NSW, *Parklea Correctional Centre and Other Operational Issues* (Report 38, December 2018) 109-115.

the timely introduction of processes for managing the risk of COVID-19 transmission posed by staff, visitors and people entering custody and additional hygiene measures. I consider that this cooperation has been essential to preventing COVID-19 outbreaks within the NSW custodial system. And I hope it may continue in efforts to meet the broader health needs of the NSW inmate population.

It is important to acknowledge that since the original on-site inspections took place there have been changes to a number of correctional centres due to new infrastructure, the role of centres changing, and changes to operational capacity of individual correctional centres.[9] The responsibility for the delivery of health services has also diversified over the course of this inspection. At the time of our on-site inspections during 2018, JH& FMHN was responsible for the delivery of health services in all but one correctional centre. Now, approximately one-quarter of the adult prison population in NSW are accommodated in privately operated correctional facilities with private health providers.[10]

The recommendations in this report address an overall strategic objective to improve health services in all custodial facilities in NSW and as such I have directed a number of recommendations to all health providers operating in the custodial system. It is acknowledged that some of the recommendations in this report have already been implemented and many are already in progress.

Fiona Rafter

Inspector of Custodial Services

March 2021

9 Corrective Services NSW will remove around 2,500 short-term and obsolete beds by about late-2021. These changes are taking place as safe new fit-for-purpose infrastructure, in new and upgraded prisons, become operational. Corrective Services NSW, Better Prisons, 2020, <https://correctiveservices.dcj.nsw.gov.au/csnsw-home/correctional-centres/better-prisons.html#:~:text=in%20Berkshire%20Park.-,Prison%20Bed%20Capacity%20Adjustment,and%20upgraded%20prisons%2C%20become%20operational>.

10 CSNSW Corrections Research, Evaluation & Statistics, *Offender Population Report*, 14 February 2021.

Acknowledgements

The Inspector acknowledges the co-operation, assistance and information provided by Justice Health & Forensic Mental Health Network, GEO and CSNSW staff during the inspections and subsequent period.

The assistance of Official Visitors at each centre also warrants acknowledgement and my appreciation. The Ombudsman, Health Care Complaints Commission, Legal Aid NSW and the Public Interest Advocacy Centre also provided an invaluable insight into complaint trends and individual case studies.

I would like to give special acknowledgment to the assistance of Dr Elizabeth McEntyre, and Eleanore Graham, and the expertise of our health consultant, Craig Gear.

I also wish to express my gratitude to the men and women in custody who were prepared to share their experiences with the inspection team.

Note: Unless otherwise specified, references to legislation in this report relate to the laws of NSW and references to legislation, policies, training materials and other documentation refer to current documents and provisions.

The Inspection considered sensitive information and methodologies. In accordance with section 15 of the *Inspector of Custodial Services Act 2012*, information that could prejudice the security, discipline or good order of any custodial centre, or identify or allow the identification of a custodial centre staff member has been removed in the public interest.

Glossary of terms and acronyms

AMS	Aboriginal Medical Service
CC	Correctional Centre
CNC	Clinical Nurse Consultant
Co-morbidity	The coexistence of substance use and mental health disorders.[11]
Cognitive Disability	An ongoing impairment in comprehension, reason, adaptive functioning, judgment, learning or memory that is the result of any damage to, dysfunction, developmental delay or deterioration of the brain or mind. It includes intellectual disability, learning disability borderline intellectual disability, and acquired brain injury.[12]
CSNSW	Corrective Services New South Wales
EN	Enrolled Nurse
FTE	Full Time Equivalent
GEO	Full name GEO Group Australia Pty Ltd is an Australian company owned by American corporation The GEO Group Inc, which provides custodial management under contracts with Australia state governments.
GP	General Practitioner
HCCC	Health Care Complaints Commission
Health centre	A medical centre within a correctional centre staffed by nurses and other clinical roles, where inmates receive health services.
HPNF	Health Problem Notification Form
IDC	Inmate Delegate Committee
ISOH	Information System for Oral Health
Inpatient	Patient who is admitted to hospital.
JH&FMHN	Justice Health and Forensic Mental Health Network including courts custodial and community post-release and forensic community support
JHeHS	Justice Health electronic Health System
LHD	Local Health District
MAU	Medical Appointments Unit, JH&FMHN
Outpatient	Patient who is 'not formally admitted to hospital' and does 'not stay overnight'[13]
Mental illness	Mental illness is defined as 'a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms: delusions; hallucinations; serious disorder of thought form; a severe disturbance of mood; and/or; sustained or repeated irrational behaviour'[14]

11 Tony Butler et al, 'Co-occurring Mental illness and substance use disorder among Australian Prisoners', (2010) 30(2) *Drug and Alcohol Review* 188.

12 New South Wales Law Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: Diversion* (Report No 135, June 2012) 136.

13 'Outpatient Services', *NSW Health* (Web page) <https://www.health.nsw.gov.au/Performance/Pages/outpatients.aspx>.

14 Lauren Costello, Melanie Thomson and Katie Jones, *Mental Health and Homelessness* (Mental Health Commission of NSW, Final Report, June 2013) 12.

Mental health issue	Mental health issues, also known as mental health problems, 'are typically less severe and of shorter duration than mental illness and may [be]… experienced as a reaction to life stressors'[15]
Mental Health services	Services to support people with mental illness or mental health issues
NP	Nurse Practitioner
NUM	Nursing Unit Manager
OST	Opioid Substitution Therapy
PAS	Patient Administration System – an electronic record system utilised in health and JH&FMHN
Primary care	The health care a patient receives upon first contact with the health care system. In the community, this is largely provided by General Practitioners. In prisons primary care is provided in the first instance by Registered Nurses[16]
Remand	Where an inmate has been charged with an offence but is yet to be convicted
RN	Registered Nurse
ROAMS	Remote Offsite Afterhours Medical Services provided by on-call JH&FMHN staff
Safe cell	A cell with CCTV and no hanging points
Secondary Care	Medical care provided by a specialist or facility upon referral by a primary care physician[17]
SEWB	Social and Emotional Wellbeing: a multidimensional concept of health that includes mental health, but which also encompasses domains of health and wellbeing such as connection to land or 'country', culture, spirituality, ancestry, family, and community and how these affect the individual[18]
STI	Sexually Transmitted Infection
Suboxone	A prescription-only film medication containing buprenorphine and naloxone, designed to treat opioid dependence[19]
Tertiary Care	Highly specialised care which is mostly provided by a hospital to a patient who has been referred from a primary or secondary health professional. It may include complex medical or surgical procedures.[20]
Titanium	Titanium electronic oral health record system
TNP	Transitional Nurse Practitioner

15 Lauren Costello, Melanie Thomson and Katie Jones, *Mental Health and Homelessness* (Mental Health Commission of NSW, Final Report, June 2013) 12.

16 Justice Health Statewide Service and NSW Health, Justice Health: Health Services Brochure (November 2009) 9.

17 Australian Institute of Health and Welfare, *Australia's Health 2016* (Australia's Health Series No. 15, 2016) 26.

18 Department of Prime Minister and Cabinet, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* (2017) 6.

19 'What is Suboxone Film?', *Suboxone* (Web Page) <https://www.suboxone.com/treatment/suboxone-film>.

20 State of Queensland (Queensland Health), 'Health System' (Fact sheet, September 2018) 4.

Executive summary

The health needs of the NSW prison population are significant and complex. The health profile and conditions of people coming into custody replicates the physical health, mental health and social determinants of the most vulnerable and disadvantaged in society.[21] The challenge within the correctional setting is to deliver health services to a population cohort with high health needs in a controlled and secure environment. These health services need to be delivered in a timely manner and to a quality comparable with health services provided to the broader NSW population.

The majority of people in custody return to the community after relatively short periods. Therefore, there is a significant public health imperative to ensuring health care is available and accessible in custody.

While this provides an opportunity to positively intervene in improving people's health it also requires the health service to be tailored and able to readily respond to these unique and specific 'offender' health needs. This requires a medical, nursing and allied health staff with a diverse range of clinical skills and expert levels of health knowledge in the areas of complex need experienced by inmates. These health professionals need to be able to readily respond to the most critical emergency situations as well as continually deliver comprehensive primary health and mental health care.

The Inmate Health Profile

Prisoners experience poorer health compared to the general population. Prisoners are more likely to have chronic illness, mental health problems, post-traumatic stress, substance use issues and communicable disease, dual diagnoses of mental health issues and physical or other health problems.[22] They are also more likely to have experience of mental health issues including anxiety, depression, psychosis and suicidal thoughts.[23]

They also experience 'accelerated ageing', where signs of ageing may occur 10 to 15 years earlier than for the rest of the population.[24] Aged inmates are defined as those over 55 years for non-Aboriginal people and over 45 years for Aboriginal people.[25]

The numbers of aged inmates in custody has increased disproportionately compared to community demographics.[26] Older inmates often have complex needs relating to health, decreased physical capacity and increased vulnerability.[27] This includes deteriorating cognition, higher rates of sub-acute chronic conditions requiring regular monitoring, and increased risk of falls due to frailty.[28] Alzheimers and other types of dementia, other cognitive disabilities and hearing loss may present extra challenges in the prison environment. The Aboriginal and Torres Strait Islander burden of disease is 2.3 times greater than the non-Indigenous burden in the general population.[29] Chronic health issues are also overrepresented among

21 Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) vi.

22 Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) vi, 49; The Royal Australian College of General Practitioners, *Standards for Health Services in Australian Prisons* (1st ed, April 2011) 2-3 ; Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 14.

23 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 52-62.

24 Australian Institute of Health and Welfare*, Australia's Health 2018* (Australia's Health Series No 16, 20 June 2019) 302.

25 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 14; CSNSW data provided on 6 December 2018.

26 Efty Stavrou, 'Changing Age Profile of NSW Offenders' (NSW Bureau of Crime Statistics and Research, Issue Paper No 123, March 2017) 1.

27 Efty Stavrou, 'Changing Age Profile of NSW Offenders' (NSW Bureau of Crime Statistics and Research, Issue Paper No 123, March 2017) 1.

28 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 14.

29 Australian Medical Association, *2018 Australian Medical Association Report Card on Indigenous Health* (November 2018) 5.

Aboriginal people.[30] Given the high rates of incarceration of Aboriginal and Torres Strait Islander people this is a significant health burden, and health intervention opportunity, within the correctional environment.

Aboriginal people make up approximately 23.1 per cent of people incarcerated in NSW correctional centres and report using health services more while in prison compared with the community.[31] This highlights the importance of having culturally competent health services in custody as for many Aboriginal people, prison is an opportunity to facilitate contact and engagement with health services, with chronic illness often detected for the first time in custody. Although women make up around 7.2 per cent of the NSW prison population,[32] they often present with 'more complex needs' than men, 'including those related to mental health and substance misuse'.[33] Aboriginal women are also overrepresented in this population, where they make up 32.7per cent of the total female custody population in NSW.[34] This health profile informs the range of services offered in custody and places significant demand upon these services.

The Availability of Services

The health care of people incarcerated in NSW correctional facilities is the responsibility of the State through the NSW Ministry of Health.[35] Justice Health & Forensic Mental Health Network (JH&FMHN) is a statutory health corporation[36] within the NSW public health system. Its core function is delivering health care to adults and young people in contact with the forensic mental health and criminal justice systems, across community, inpatient and custodial settings.[37] JH&FMHN provides health services to inmates in 33 of the 36 correctional centres in NSW.[38]

The services provided in the remaining three of 36 correctional centres are provided by contracted and sub-contracted private health service providers. The delivery of health services by private or sub-contracted service providers is monitored by JH&FMHN.[39] The responsibility for clinical governance for those three correctional centres sits with the private or sub-contracted health services.

The health needs of prisoners in NSW requires a broad and expanded scope of health practice and service provision by prison health service providers, across primary health, mental health, drug and alcohol, public health and women's health. This needs to supported by ongoing adequate training, supervision and credentialing for all health staff and particular primary care nurses and those with extended scopes of practice, with avenues for identifying and addressing skill gaps.

30 *The 2018-19 Australian Bureau of Statistics National Aboriginal and Torres Strait Islander Health Survey found that chronic health issues are also overrepresented among Aboriginal people, where 46% of participants had at least one chronic condition that posed a significant health problem,* Australian Bureau of Statistics, *Results from the 2018-19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)*, December 2019, p.2; Edith Cowan University, *Summary of Aboriginal and Torres Strait Islander health status 2019*, 15 June 2020, pp. 1-37 <https://healthinfonet.ecu.edu.au/learn/health-facts/summary-aboriginal-torres-strait-islander- health/40279/?title=Summary%20of%20 Aboriginal%20and%20Torres%20Strait%20Islander%20health%20status%202019&contentid=40279_1>.

31 *Kariminia, A., Butler, T. and Levy M. in a paper published in the Australian and New Zealand Journal of Public Health 2007 vol. 31 no. 4.*

32 'Custody Statistics: Custody Reports', *NSW Bureau of Crime Statistics and Research* (Web page, updated as at 6 November 2019) <https:// www.bocsar.nsw.gov.au/Pages/bocsar_custody_stats/bocsar_custody_stats.aspx>.

33 Mental Health Commission of New South Wales, *Living Well: A Strategic Plan for Mental Health 2014-2024*, (2014) 82.

34 Australian Bureau of Statistics, *Results from the 2018-19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)*, December 2019, p.2

35 Section 19(2) of the *Health Insurance Act 1973* (Cth) provides that health services are not eligible for Medicare benefit if the services are provided by state or territory governments. See also Department of Health (NSW), *2018-19 Service Agreement: An Agreement Between Secretary, NSW Health and the Justice Health and Forensic Mental Health Network* (29 November 2018) 4: 'Commonwealth legislation provides that all persons on remand and convicted prisoners are ineligible to use their Medicare card for the purposes of accessing public health services whilst in custody, as prisoner health care is the responsibility of State and Territory Governments.'

36 *Health Services Act 1997.*

37 Justice Health and Forensic Mental Health Network,*Year in Review 2016*-17(Department of Health (NSW), December 2017) 5.

38 Information provided by CSNSW September 2020.

39 Information provided by JH&FMHN 2018.

The Inspection found that population health is a strength of JH&FMHN. The identification, management and treatment of Hepatitis C is a particular focus and achievement in NSW. In the 2015 *Network Patient Health Survey*, 24.2% of females and 20.4% of males reported a diagnosis of Hepatitis C.[40] The hepatitis treatment program in custody delivers significant long term health benefits to the community, including the potential for reductions in Hepatitis C transmission and health system cost burden. JH&FMHN should be commended on their significant work in this area that has resulted in this important public health intervention that benefits not only the custodial environment but the broader community.

A key drug and alcohol service available in correctional centres is the commencement or continuation of Opioid Substitution Therapy (OST). NSW correctional centres provide OST in the form of methadone syrup, buprenorphine wafers, suboxone film and long-lasting injectable buprenorphine.[41] OST dosing was observed in all centres inspected, and a high standard of safety and accuracy was demonstrated by all staff involved. JH&FMHN and contracted private health providers have also commenced long-lasting intramuscular buprenorphine injections, known as a depot, for people commencing OST in custody. The injections last for one month.[42] This has allowed increased access to OST and the freeing up of valuable nursing hours to provide focus on higher value health interventional tasks. JH&FMHN and the contracted private health providers are to be acknowledged for the significant work in fast tracking implementation. It has substantial benefits for the custodial environment and public health more broadly.

The COVID-19 pandemic has presented a new and unprecedented risk to the health of inmates and all staff working within the correctional environment. It was widely recognised that COVID-19 could quickly spread within correctional centres, and therefore among a population more likely to have health conditions that make them susceptible to developing a serious COVID-19 infection. The timely introduction of processes to prevent COVID-19 transmission in custodial facilities has been essential to averting COVID-19 outbreaks within the NSW correctional system. The significant contribution and leadership that JH&FMHN (along with the implementation of the JH&FMHN policies and procedures by contracted private health providers) has made to public health in preventing the transmission of COVID-19 within the custodial environment cannot be overstated. The cooperation and collaborative support of CSNSW and contracted private operators must also be acknowledged and commended.

The complex health needs of Aboriginal people have long been recognised at a national level through the National Agreement on Closing The Gap.[43] The Closing The Gap targets have recently been expanded to include the reduction of the incarceration rates of Aboriginal and Torres Strait Islander adults and young people.[44] This national acknowledgement of the interaction of criminogenic and health factors in the future wellbeing of Aboriginal people suggests priority needs to be given to considering dual approaches and specific initiatives in Aboriginal Health to Close The Gap.

Embedding Aboriginal Health Workers or registered Aboriginal Health and Torres Strait Islander Health Practitioners in NSW correctional health centres, with appropriate professional supports for this workforce, is likely to improve engagement of Aboriginal inmates with prison health services. The Inspections found an absence of Aboriginal Health Workers and registered Aboriginal and Torres Strait Islander Health Practitioners employed in health centres. JH&FMHN and contracted private providers are aware of this

40 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 35.

41 Suboxone is the commercial name for a pharmaceutical containing buprenorphine and naloxone, see Department of Health (NSW), *NSW Clinical Guidelines: Treatment of Opioid Dependence 2018* (Abbreviated version, July 2018) 4.

42 Justice Health and Forensic Mental Health Network, *2018 Enabling Plan* (Version 2.0, July 2018) 10; Justice Health and Forensic Mental Health Network, Treatment for Drug Use, Fact Sheet for inmates, 8 May 2020.

43 Closing the Gap: In Partnership, *National Agreement on Closing the Gap* (July 2020). <https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf?q=0720>.

44 Closing the Gap: In Partnership, *National Agreement on Closing the Gap* (July 2020) 26 <https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf?q=0720>.

challenge and are currently undertaking development of their Aboriginal workforce.

Increasing the Aboriginal workforce is critical for the delivery of comprehensive cultural safe primary health services provided to Aboriginal inmates. Under Close The Gap, this has been identified as a key strategy to improve engagement with health services and improved health outcomes for Aboriginal and Torres Strait Islander peoples. Equally important is a culturally responsive mainstream workforce. The Inspector acknowledges and supports the work of the JH&FMHN Aboriginal Strategy and Culture Unit and their inclusion in the executive level of the organisation. Despite this, the inspection found there is significant work to be done to prioritise and embed culturally safe primary health care and social and emotional wellbeing services for Aboriginal inmates in NSW correctional centres.

Custodial mental health relates to the mental health services provided to people incarcerated in NSW prisons. It comprises graduated levels of care and includes specialised facilities at the Mental Health Screening Unit (MHSU), Metropolitan Remand and Reception Centre (MRRC), and Long Bay Hospital 1(LBH 1).[45] Inmates whose mental illness is so acute that it is unable to be managed at the correctional centre where they are accommodated, may be referred to either the MHSU within the MRRC, or the Mental Health Ward of LBH1. The inspection found the capacity and timely access to these acute mental health services was inadequate.

The Demand for Health Services

This inspection found that the model of offender health provided by JH&FMHN is comprehensive and is supported by good clinical governance and a continuous improvement approach. However, there is a general under-resourcing of the correctional health system because demand outstrips supply. JH&FMHN, and any private contracted health service providers, need to be appropriately resourced and have a robust and sustainable funding model to meet the demand for prisoner health services.

Overall inmate population increases, combined with high numbers of inmates moving through the custodial system each year even for short periods, has placed extra demand on health services for inmates in correctional centres in NSW. This is because each person entering the correctional environment, even for the shortest period of time, needs to be fully assessed from a health, welfare and safety perspective. Previously prescribed medication needs to be confirmed, ordered and administered (within a secure environment) and both current and emerging acute and chronic health issues need to be identified, assessed and managed.

This is different from what a health service in the community would be expected to do due to the custodial environment and patient profile. This is the predominate workload of health professionals working within the custodial environment. This also diverts nursing, medical and other health professional time from the delivery of acute and chronic health interventions this vulnerable and disadvantaged high needs population requires, both for themselves and for the community to which they will return.

Although increased demand for custodial health services is not unique to NSW, what is unique to the NSW correctional system within the Australian context is the number of correctional centres, many of which are located in regional areas.[46] Crowding, court appearances, program availability, and classification and placement decisions result in a significant number of transfers between correctional centres each year.[47]

45 There is also a MHSU at Silverwater Womens Correctional Centre (SWCC).

46 There are a total of 53 correctional custodial facilities in NSW as at 30 June 2019, see Report on Government Services, *Corrective Services* (2020) Table 8A.3. ;See 'Correctional Centres in NSW', *Department of Communities and Justice: Corrective Services;* <https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/custodial-corrections/table-of-correctional-centres/correctional-centres.aspx>.

47 In 2018 there were 54342 transfers between correctional centres.

Each transfer and discharge requires health staff to conduct health assessments, identify high-risk patients, maintain continuity of care, and facilitate timely and accurate continuation of essential medication (such as antipsychotic medications). This involves significant record keeping as well as patient engagement and must occur in addition to the provision of primary care and medication to the inmates accommodated in centres. The sheer number of people moving through the system each year places significant pressure upon prison health resources.

Not all health services are able to be delivered within a correctional centre. Inmates are presenting with more chronic and complex illnesses and co-morbidities and this can require secondary specialist care through outpatient appointments or tertiary care in specialised inpatient facilities available at the Long Bay Hospital (LBH) and a Secure Annex within the Prince of Wales Hospital, both of which are gazetted correctional facilities. Local public hospitals are utilised for acute and critical care, and in emergencies, under custodial supervision.

External scheduled and unscheduled medical escorts are frequently required to provide adequate secondary and tertiary level health care to inmates. Both types of medical escorts are essential but impact the correctional system from a transport, human resources and security perspective as attendance or admission to public hospitals requires full-time custodial supervision. External medical escorts, despite the best efforts of CSNSW, can impact on the planned and scheduled access to in-centre health services. When this occurs on the day or time when specialist psychiatry or other in-reach specialist health services are on-site the trade-off and cost can be high impact, both from a budgetary perspective and importantly for the health outcomes and clinical risk at the individual patient level.

There is no suggestion that JH&FMHN or other contracted health service providers are sending inmates to public hospital emergency departments unnecessarily, however increased use of telehealth may reduce the number of scheduled medical escorts for outpatient services. Moreover, a dedicated regionalised but state-wide medical escorts unit will minimise the impact of scheduled and unscheduled medical appointments on correctional centre staffing and ensure inmates attend their scheduled appointments.

CSNSW has recently piloted a dedicated medical escorts unit and is now completing a business case for a permanent medical escorts unit.[48] Next steps should consider an appropriately resourced and funded approach to scheduled appointments in regional hubs.

Given the prevalence of mental illness within the custodial population, the inspection found that demand for custodial mental health beds outweighs supply. NSW is not alone in trying to manage the demand for acute mental health services in the correctional system.[49]However, at the time of the on-site inspections, JH&FMHN was unable to report on the numbers of inmates waiting for a mental health bed. Monitoring waitlist numbers and the acuity of patients on the waitlist assists in quantifying the extent of the demand. JH&FMHN have implemented a system to monitor waitlists for mental health beds.

The inspection found that the 43-bed MHSU, 40-bed mental health unit at LBH1, and 138-bed step-down Hamden unit at MRRC are insufficient to meet the demand for mental health beds. Availability of mental health beds is not solely impacted by the demand for beds. It is also impacted by 'bed block'; where patients cannot access a bed because the bed is occupied by a patient who is ready to be discharged but is waiting for a bed to become available in another facility with a lower but appropriate level of care. In this regard, the recent announcement of an additional 150 mental health beds at Long Bay Hospital and the Metropolitan Special Programs Centre is welcomed.[50]

48 Information provided by CSNSW 4 February 2021.

49 Andrew Forrester et al, 'Mental Illness and Provision of Mental Health Services in Prisons' (2018) 127 *British Medical Bulletin* 101, 105; Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) 27-8.

50 Information provided by CSNSW 4 February 2021.

Better Access to Health Services

The challenge for health services being provided in NSW correctional centres is to provide all elements of comprehensive primary health, as occurs within the general community, in a restricted environment and to a population with generally poor health, and particularly high needs in the areas of mental health and drug and alcohol.

The difference within the correctional setting is that due to the controlled and secure environment, both patient and health professional have limited access periods to each other. Priority must also be afforded to emergency care and response to trauma, non-intentional injury, medical and life-threatening emergencies and conditions. Therefore the choice and timing of the patient to see a nurse or GP is necessarily constrained more so than in the community.

Aged and frail inmates face additional challenges in accessing health care. Age and frailty should not be a barrier to accessing adequate healthcare. Innovative responses from JH&FMHN, CSNSW and private providers are required to meet the needs of this population.[51]Agencies should be resourced such that they are able to respond to this challenge, and relationships with private providers with expertise in providing aged care services should be explored. Given the increase in the number of aged inmates between 2015 and 2019, additional beds for aged inmates are required in the system. In August 2020 CSNSW announced the creation of an additional 100 beds for aged inmates in metropolitan Sydney. This will go some way to addressing the need.[52]

A genuine culture of collaboration and communication between custodial and health providers will help improve access to health services. Improving cooperation may be challenging and difficult to measure. However, the inspection team observed that it is possible. This was particularly evident at John Morony CC and Junee CC. CSNSW and JH&FMHN should continue to work together to improve access to health services.

The standard of health care provided to inmates should be comparable to that available in the community.[53] Wait times between a patient being placed on a waitlist to seeing a nurse or medical practitioner was found at times to be lengthy. This can be exacerbated by transfers between centres. At correctional centres with a high number of transfers, nurses spent significant time reviewing and reprioritising waiting lists. JH&FMHN have responded by creating efficiencies in dispensing medication, analysing waitlists and investing in electronic records and telehealth. Given the increasing number of inmates moving between private and publicly operated correctional centres it is important that all health providers share information and have access to the same electronic information systems upgrades. Having consistent key performance indicators for health service delivery across public and private health service providers in the correctional system should also assist in measuring performance and improving outcomes, comparability and contestability.

Since the inspection, JH&FMHN has implemented a centralised GP and specialist telehealth service. Increasing the use of telehealth for GP and specialist services should have a significant impact on waitlists, and prisoner movement. During 2018-19 there was a 335% increase in the number of patients seen by GPs and a 20% reduction in waiting times. This demonstrates a significant return on the investment in telehealth technology. Moreover, during the COVID-19 pandemic telehealth has been embraced and should become a mainstay of custodial health service.

JH&FMHN does very well to adapt and respond to the changing environment however service delivery needs to be regularly reviewed to ensure efficiency and effectiveness. The inspection found that access to primary care is not at a level comparable to the community, where a person may present at a GP surgery or emergency department. This is predominantly due to resource limitations, access limitations and environmental constraints of correctional centres. In the majority of NSW correctional centres JH&FMHN

51 Information provided by GEO 21 January 2021, *HS 2.18A Caring for Older Patients and Those with a Disability and a supplementary Policy Guide for Health Services Staff HS 2.28B.*

52 Information provided by CSNSW August 2020.

53 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), GA Res 70/175, UN Doc A/RES/ 54/254 (8 January 2016, adopted 17 December 2015) rule 24(1)'.

provide nursing coverage augmented with limited GP hours.

It is therefore timely to review the model of custodial health care to ensure the nursing dominated, GP supported, JH&FMHN model of care is able to deliver health care to a standard comparable with the community, and that the nursing scope of practice and skill level is appropriate to respond to the health profile of the custodial environment.

A longstanding barrier to the implementation of a GP led model of care consistent with primary health care in the community is the availability and funding of a GP (and Nurse Practitioner) workforce, and the inability for prisoners to access Medicare. Further advocacy is required in the area of access to Medicare as this will assist in achieving a comparable level of care and continuity of primary care. This is particularly important for ensuring that Aboriginal prisoners can access and receive the level of care required to meet the Close The Gap targets recently announced by the Commonwealth Government. These now include targets for reduction in Aboriginal and Torres Strait Islander rates of recidivism. This initiative will also drive post release connection to Aboriginal Community Controlled health services, or a mainstream health service. The particular focus should be in relation to assessment and health checks for Aboriginal and Torres Strait Islander people (MBS Item 715), chronic care planning and review by a GP or primary care team (MBS Items 721, 723 and 732) and possibly other follow up heath services for Aboriginal and Torres Islander people who have had a health assessment. This is a health equity and continuity of care provision which should be able to be supported under future Close the Gap strategies.

Despite the efforts of JH&FMHN and the private health providers, barriers to accessing health services remain, emerging from a) the delivery model of health services; b) the impact of custodial regimes and systems on demand for health services and access to health services; c) the need for greater investment in Aboriginal health, aged care, drug and alcohol and mental health services; and d) the need for greater coordination between JH&FMHN, private health providers and CSNSW.

This report therefore makes recommendations to improve the delivery of health services across the custodial system including:

- Reviewing the model of health service delivery to ensure its efficiency and effectiveness.
- Ensuring custodial health services are resourced commensurate to the size of the prison population and to deliver health services equivalent to a community standard.
- Increasing the availability of Aboriginal health, mental health and drug and alcohol services.
- Continuing to invest in staff training and addressing skill gaps to meet service needs.
- Assisting JH&FMHN and private health providers to improve efficiencies in health service delivery through increased use of telehealth and efficient medication dispensing.
- Creating efficiencies by reducing prisoner movements in the system and implementing a dedicated medical escorts unit.
- Encouraging JH&FMHN, private health providers and CSNSW to work together to increase access to health services.

Recommendations

The Inspector recommends:

1. A review of the custodial health delivery model occurs to ensure health care provided to inmates is comparable to that available in the community.

2. JH&FMHN ensure the shared model of care is supported by ongoing adequate training, supervision and credentialing for all primary care nurses, with avenues for identifying and addressing skill gaps.

3. CSNSW and JH&FMHN regularly review the Risk Intervention Team model including the staffing makeup of the Risk Intervention Team, therapeutic interventions, and review procedures in all correctional centres including privately operated facilities.

4. JH&FMHN record and monitor waitlists for the Mental Health Screening Unit to accurately assess demand for services.

5. CSNSW and JH&FMHN develop a shared strategy for mental health given the size of demand and the resource implications for both agencies.

6. CSNSW increase the number of acute, sub-acute, step-down and mental health screening beds available in the system and collaborate with JH&FMHN and other stakeholders around appropriate models for operation.

7. CSNSW consider locating sub-acute mental health beds for sentenced inmates at a correctional centre housing sentenced inmates and step-down mental health beds for remand inmates at a remand centre.

8. Standardise targets for vaccinations and BBV/STI screening and treatment targets across public and private health providers.

9. CSNSW and JH&FMHN through the Harm Reduction Reference Group (HRRG) continue to consider the research and benefits of current and alternate harm minimisation approaches.

10. Health service providers ensure health promotion activities for a range of literacy levels and cultural backgrounds take place at all correctional centres.

11. CSNSW and JH&FMHN prioritise the full implementation of long-acting/injectable OST.

12. A range of medical and non-medical drug and alcohol interventions should be available to all inmates regardless of sentencing status.

13. Accredited Aboriginal-specific drug and alcohol programs are made available in all correctional centres, with special attention to course content, facilitator, delivery setting, and retention strategies.

14. CSNSW review the delivery of Remand Addictions and ensure delivery targets are met at correctional centres.

15. All health service providers bring their level of service in relation to culturally safe comprehensive primary health care for Aboriginal inmates in line with JH&FMHN policies and practices and equivalent community standards.

16. JH&FMHN and private health providers staff all correctional centres with Aboriginal and Torres Strait Islander Health Workers/ Practitioners, and identified Aboriginal health staff and collaborate with relevant peak bodies regarding clinical and cultural support.

17. JH&FMHN and private health providers continue to explore partnerships with Aboriginal Medical Services and funding models to support provision of culturally safe primary health care.

18. Advocating for a trial for access to Medicare for Aboriginal inmates and/or MBS items for Aboriginal and Torres Strait Islanders where the current services are unable to meet comparable community service models for Aboriginal and Torres Strait Islander people in the community.

19. All custodial and health service providers increase the cultural competency and cultural safety of their workforce, and support this with ongoing training, supervision and leadership.

20. CSNSW and JH&FMHN, and the private custodial and health providers, develop an Aboriginal social and emotional wellbeing plan to support connection to culture and social and emotional wellbeing for Aboriginal inmates.

21. JH&FMHN continue to explore options for saving time on dispensing medication to allow nursing staff to focus on health assessments and primary health clinics.

22. JH&FMHN is funded commensurate to the demand for pharmaceutical expenses.

23. Allow Junee CC and other private health providers to access the JH&FMHN dental waitlist.

24. CSNSW provide necessary hygiene items to all inmates.

25. CSNSW implement an appropriately planned and resourced Medical Escorts Unit to service key regional and metropolitan hubs.

26. JH&FMHN, private health providers, and CSNSW work together to ensure information sharing occurs in accordance with policy.

27. JH&FMHN and private health providers delivering reception assessments provide education and training programs and ensure staff are trained to conduct Reception Screening Assessments, initial competency is confirmed, ongoing competency maintained, and ensure staff are afforded opportunities to address knowledge gaps.

28. JH&FMHN and private health providers ensure the health screening process for interfacility transfers is optimised by a thorough health assessment.

29. CSNSW and health providers work together to allow inmates to access the clinic to make requests in person to supplement the paper-based request system; explore mechanisms for improving access to the clinic for lower literacy and lower mobility inmates; and implement auditable systems that record requests for health services.

30. CSNSW and private providers ensure paper-based self-referral forms and locked boxes are freely available to inmates in a number of settings including accommodation, library and employment areas to allow unfettered and confidential access.

31. CSNSW and other private operators develop a system for recording, monitoring, and auditing after-hours intercom use.

32. JH&FMHN and private health providers further develop advanced nursing practice and Nurse Practitioners to increase the access to timely primary care.

33. JH&FMHN and private health providers continue to explore innovations in managing waitlists, and consider appropriate targets for waiting times for each health service and mitigation action if these are not met.

34. JH&FMHN and private health providers and CSNSW and private operators develop an action plan for each correctional centre to increase patient access to the health centre for treatment from 0800hr – 1130hr and 1230hr to 1430hr and provide sufficient escort and supervision to allow all clinic rooms to be utilised for maximum efficiency.

35. JH&FMHN and private health providers should continue to examine clinic level data for GPs and develop solutions to improve performance where required.

36. CSNSW ensure that all future capital works for health centres are:

    a. designed with the collaboration of JH&FMHN or the relevant private health provider from the outset

    b. commensurate to the size of the inmate population

    c. designed with privacy and flow in mind, for example, sufficient holding rooms, waiting areas, screening of medication dispensing areas from correctional centre traffic, and large windows for supervision and line of sight without audibility.

37. CSNSW or private operator staff assisting with health centre escorts and supervision ensure that inmate privacy and confidentiality is maintained.

38. JH&FMHN and CSNSW jointly review Management Service Agreements to improve patient access and flow, including during lockdowns if it is safe to do so, and develop an escalation policy to trigger joint teamwork and intervention where issues emerge.

39. JH&FMHN and private health providers monitor workforce trends, develop a workforce management strategy, and continue to develop innovative solutions to address service delivery gaps.

40. JH&FMHN and private health providers expand and maximise telehealth to fill service delivery gaps and increase patient access to care.

41. CSNSW support JH&FMHN use of AVL suites and digital cameras for telehealth.

42. CSNSW with JH&FMHN create sufficient aged care beds in the Sydney metropolitan area with regard to an appropriate physical environment for ease of basic living such as ambulating and showering, and adequate levels of access to health services.

43. CSNSW ensure eligible inmates who are terminally ill are aware of the ability to apply for parole.

44. JH&FMHN include GEO and other private health providers within the implementation of Titanium, PACS/RIS, JHeHS functionality upgrades and any future electronic information system upgrades.

45. JH&FMHN should develop procedures in relation to use and review of the My Health record.

46. JH&FMHN and NSW Health support the plan to migrate to a single integrated e-health record, including electronic medication management and prescribing, in line with current scheduled timeframes.

47. JH&FMHN and the private health providers support discharge planning for selected Aboriginal and complex primary care level patients.

48. Consideration should be given to ongoing advocacy to allow inmate access to Medicare, particularly in the area of Aboriginal health services and complex primary care level patients.

49. JH&FMHN and CSNSW consider consistent KPIs for health service delivery across public and private health service providers.

50. JH&FMHN are resourced commensurate to size of the prison population, with regard to wage price index and health price index.

51. The Inspector recommends that this report is made public immediately upon being tabled in NSW Parliament, in accordance with section 16(2) of the *Inspector of Custodial Services Act 2012 (NSW).*

Chapter 1. Introduction

1.1 The Inspector of Custodial Services

The Inspector of Custodial Services (ICS) was established in October 2013 by the *Inspector of Custodial Services Act 2012* (the Act). This Act provides for the independent scrutiny of the conditions, treatment and outcomes for adults and young people in custody, and the promotion of excellence in staff professional practice.

The principal functions of the Inspector, as set out in section 6 of the Act, are as follows:

- to inspect each custodial centre (other than juvenile justice centres and juvenile correctional centres) at least once every 5 years,
- to inspect each juvenile justice centre and juvenile correctional centre at least once every 3 years,
- to examine and review any custodial service at any time,
- to report to Parliament on each such inspection, examination or review,
- to report to Parliament on any particular issue or general matter relating to the functions of the Inspector if, in the Inspector's opinion, it is in the interest of any person or in the public interest to do so,
- to report to Parliament on any particular issue or general matter relating to the functions of the inspector if requested to do so by the Minister,
- to include in any report such advice or recommendations as the Inspector thinks appropriate (including advice or recommendations relating to the efficiency, economy and proper administration of custodial centres and custodial services),
- to oversee Official Visitor programs conducted under the *Crimes (Administration of Sentences) Act 1999* and the *Children (Detention Centres) Act 1987*,
- to advise, train and assist Official Visitors in the exercise of the functions conferred or imposed on them under those Acts, and
- such other functions as may be conferred or imposed on the Inspector under this or any other Act.

1.2 Background to the inspection

A number of factors informed the decision to inspect correctional centres in relation to the provision of health services to inmates.

Prisoners experience poorer health compared to the general population. They are more likely to have chronic illness, mental health problems, post-traumatic stress, substance use issues and communicable disease.[54]

A custodial environment characterised by increasing inmate numbers, high health needs, significant movement through the system, high levels of inmate complaint and publicly identified resourcing concerns suggests a challenging environment for the provision of health services to inmates.

54 Australian Institute of Health and Welfare, *Australia's Health 2018* (Australia's Health Series No. 16, 2018) 300; The Royal Australian College of General Practitioners, *Standards for Health Services in Australian Prisons* (1st ed, April 2011) 2-3; Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 14.

Complaints data also suggests medical issues are an area of concern for inmates. In 2016-2017 and 2017-2018, medical issues were the highest category of complaints received from inmates by NSW Official Visitors.[55] This is a rate of 17.9 complaints per 100 inmates for the period 2017-2018.[56] In 2016-2017, medical issues were the highest area of complaint made to the NSW Ombudsman, and the second-highest category in 2017-2018.[57] For the period 2017-2018, 19.6% of all inquiries or complaints received by the NSW HCCC regarding the provision of health services came from inmates in NSW correctional centres.

The ICS therefore determined to look at the availability of health services to inmates, and how inmates access those services.

On 28 February 2018, the ICS published the following Terms of Reference for an inspection into the provision of health services in NSW correctional facilities:

- relevant legislation and standards
- the operation of different service delivery models, including policies, procedures and practices
- the health status and needs of inmates
- the health services available to inmates, including primary, specialist and allied health services
- inmates' access to health services, including the impact of resourcing and custodial regimes
- any other related matter.[58]

1.3 Terminology

The inspection adopts the definition of **'health care'** provided by the Australian Commission on Safety and Quality in Health Care (ACOSQHC) as 'the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.'[59] JH&FMHN are accredited to the Commission's *National Safety and Quality Health Service Standards*.[60]

Rule 24 of the *Mandela Rules* state health services provided to prisoners should be of a comparable standard to the community.[61] The *Guiding Principles for Corrections in Australia* states that prisoners are provided a standard of health care equal to services available in the community.[62] '**Comparability**' of health services in prisons means that the range of health services and the standard of clinical care should be the same between prisons and the community. It is acknowledged that the custodial environment is a securitised environment, and this can impact freedom of movement and access.

55 Inspector of Custodial Services (NSW), *Annual Report 2016-17* (December 2017) 13; Inspector of Custodial Services (NSW), *Annual Report 2017-2018* (October 2018) 16.

56 Inspector of Custodial Services (NSW), *Annual Report 2017-2018* (October 2018) 16.

57 Ombudsman (NSW), *Annual Report 2016-2017* (20 October 2017) 83; Ombudsman (NSW), *Annual Report 2017-2018* (22 October 2018) 82.

58 'Available' means what is able to be used or obtained. 'Access' is understood as the means or opportunity to approach or obtain something.

59 Australian Commission on Safety and Quality in Health Care, 'Australian Open Disclosure Framework' (Report, 2014) 2 cited in Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd edition, November 2017) 71.

60 See 'Australian Health Service Safety and Quality Accreditation Scheme', *Australian Commission on Safety and Quality in Health Care* (Web Page) <https://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/>; ' The NSQHS Standards', *Australian Commission on Safety and Quality in Health Care* (Web Page) <https://www.safetyandquality.gov.au/standards/nsqhs-standards>.

61 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), GA Res 70/175, UN Doc A/RES/ 54/254 (8 January 2016, adopted 17 December 2015) rule 24(1).

62 Corrective Services Administrators' Council, *Guiding Principles for Corrections in Australia* (February 2018) part 4.1.4.

1.4 Methodology

Six facilities were inspected for this report: Tamworth Correctional Centre, Cessnock Correctional Centre, Shortland Correctional Centre, Junee Correctional Centre, John Morony Correctional Centre and the Secure Annex at the Prince of Wales Hospital.

These centres were chosen because they display a range of models for the delivery of health services across public and private providers in NSW. The Secure Annex was selected for inspection because of its unique role in providing acute inpatient health service to NSW inmates. The centres chosen are male centres with women's units attached to Junee and Cessnock.

The Metropolitan Remand and Reception Centre, Long Bay Hospital 1 and Silverwater Women's Correctional Centre were also visited in relation to this inspection as they host specialised health facilities for NSW inmates.

The inspection team included the Inspector, a Senior Inspection and Research Officer, an Inspection and Research Officer, an independent consultant with a background in justice health and health management, and an independent Aboriginal consultant with a background in mental health social work and criminal justice.

The dates of inspections were:

- Secure Annex, Prince of Wales Hospital, Randwick — 7 March 2018
- Tamworth Correctional Centre — 19 - 21 March 2018
- Shortland Correctional Centre — 1 - 2 May 2018
- Cessnock Correctional Centre — 3 - 4 May 2018
- Junee Correctional Centre — 4 - 7 June 2018
- John Morony Correctional Centre, Windsor — 10 – 12 July 2018[63]

The planning phase of inspections benefited from meetings and information sharing with executives of CSNSW, JH&FMHN, GEO and the HCCC. Prior to each inspection, an information request was submitted to the Governor and Nurse Unit Manager of each centre to establish key information about the inmate profile of the centre and health services provided.

The inspection team consulted with Nurse Unit Managers and Governors on inspection schedules, with the aim of achieving a broad understanding of the operations of each health centre in the limited time available, without impacting upon the delivery of health services to inmates. All areas of each correctional centre were visited, including administration, accommodation, industries and offender services areas however a significant proportion of the inspection period was spent in health centres.

Semi-structured interviews and group discussions with custodial, offender services and health staff took place. Visiting medical officers such as psychiatrists and General Practitioners (GPs) were also interviewed. The inspection team made themselves available via phone and email to any staff members who were not present during inspection and wished to provide information.

Inmate Delegate Committees were met with at each centre in a private forum. Inmates were also spoken with in their accommodation wings, employment areas and the health centre. The inspection team obtained consent from inmates before discussions and offered inmates the choice of speaking with the ICS individually or in groups.

63 A number of follow up inspections took place to centres in 2019.

Relevant documentation and data were requested from JH&FMHN, CSNSW, GEO and each correctional centre following the inspections.

Information gathered during inspection was supplemented by a range of research tasks including:

- Reviewing relevant academic literature and reports from other jurisdictions
- Desk-based research and analysis of legislation, policy and procedural documents
- Reviewing qualitative and quantitative data provided by JH&FMHN, CSNSW and GEO
- Reviewing reports by Official Visitors
- Meeting with Directors of JH&FMHN Operations and Nursing; Aboriginal Strategy and Culture; Performance and Planning; and Services and Programs.
- Visiting the JH&FMHN Pharmacy
- Liaison visits to Long Bay Hospital 1 and 2, the ACMU at MSPC1, and the MRRC
- Discussions with the JH&FMHN Medical Appointments unit and Nurse Manager, Access and Demand
- Meeting with CSNSW Medical Escorts Project
- Meeting with GEO Clinical Governance
- Visiting the Alexander Maconochie Centre, ACT
- Visiting Ravenhall Correctional Centre, Victoria
- Meeting with the Tamworth Aboriginal Medical Service
- Meeting with Winnunga Nimmityjah Aboriginal Health Service, ACT

A draft report or relevant parts thereof was provided to CSNSW, JH&FMHN and GEO in accordance with section 14(2) of the ICS Act. Submissions were received from CSNSW, JH&FMHN and GEO. In accordance with section 14(1) of the ICS Act, the Inspector provided the Minister for Corrections and Counter Terrorism with the opportunity to make a submission in relation to the draft report. In accordance with section 14(3) of the ICS Act, each submission and the Minister's response was considered before the finalisation of the report for tabling.

1.4.1 Limitations

Concurrent to inspections for this report, the ICS conducted an inspection examining the treatment and conditions of women on remand in NSW correctional centres. This involved the inspection of four correctional centres accommodating female inmates and the provision of health services in those facilities. The ICS also inspected all 24-hour court cell complexes in NSW and made findings and recommendations relating to the provision of health services. Accordingly, it was decided that this inspection would focus mainly on health services in male correctional centres. This limitation was mitigated by inspection teams sharing relevant information with each other. Further, the inspection team spoke with the small number of female inmates accommodated at Cessnock Correctional Centre.

It is acknowledged that inspections capture a snapshot in time, with understanding and observations limited by time spent on site. Information obtained onsite was complemented by additional data obtained post-inspection. Conclusions are therefore drawn from the period of observation and additional data.

1.5 Overview of the custodial facilities we inspected

The centres selected for inspection were chosen to provide the inspection team with a range of centres located in regional and metropolitan centres, performing different functions, utilising different models of health care and with different health service providers. An overview of the role and function of each facility is provided below.

1.5.1 Secure Annex, Prince of Wales Hospital, Randwick

The Secure Annex is a small hospital ward and gazetted CSNSW correctional facility located within the Prince of Wales Hospital, Randwick. Health services are provided by the Hospital which is part of South-Eastern Sydney Local Health District (LHD) (separate to JH&FMHN). Custodial supervision of patients is provided by CSNSW. One officer is required to supervise each minimum security inmate, and two to three officers are required to supervise each maximum security inmate. At the time of inspection, there were three inmates in the annex.

The annex has a four-bed ward, a three-bed ward and a single-bed ward. It is rare that all beds will be utilised at the same time due to the need to maintain separation depending on gender, classification, offences or health needs. Decisions about bed placement are made on a case-by-case basis.

Most patients stay in the Secure Unit for relatively short stays, up to a couple of weeks. Patients can speak to their family by telephone in the evening and have visits on the weekend. Providing palliative care for patients nearing the end of life is a large part of the unit's work. Post-operative care for acutely unwell patients is also provided in the unit.

Image 1: Secure Annex at Prince of Wales Hospital[64]

64 Sydney Building Projects, *Health and Aged Care* (Web page) <https://sbp.net.au/projects/health-aged-care/>.

1.5.2 Tamworth Correctional Centre

Tamworth CC is an 89-bed medium security facility for men with capacity for up to 25 minimum security sentenced inmates. The centre is located in the Northern Tablelands, 400 kilometres north of Sydney. At the time of inspection, on 19 to 21 March 2018, it was functioning as a reception centre for Tamworth and surrounding regions. Around the time of the inspection, 63% of inmates were Aboriginal.

Image 2: Entrance to Tamworth Correctional Centre

Remand inmates are accommodated in cells in a two-storey brick structure built in the 1800s. Inmates have access to a narrow rectangular yard adjacent to the accommodation block. Minimum security inmates are accommodated in single cells in demountable buildings at the rear of the correctional centre. The minimum and remand accommodation areas are separated by a small oval / green area which may be used by inmates, subject to staff supervision.

The health centre is small, comprising a small medication room, a treatment/consultation room, storage room and an office used for multiple purposes including telehealth and storage. Nurses are on shift from 8:00am to 8:30pm Monday to Friday and 9:30am to 6:00pm on weekends. Staffing comprises a full time Nurse Unit Manager (NUM) who is in charge of the health services within the centre, one full time RN, three part time RNs, and a part time administrative assistant. A GP visits the centre four hours per week.

While the centre holds a relatively small number of inmates, the number of movements in and out of the centre is comparable with a much larger centre. This places considerable pressure on the small health centre. In the 2018 calendar year, the centre had:[65]

- 703 new receptions
- 859 movements out to court
- 468 transfers to the centre
- 210 inmates discharged from the centre

65 Information provided by CSNSW, 8 April 2019.

At the time of inspection, there were two inmates on Opioid Substitution Therapy (OST), five inmates using monthly medication packs and 39 inmates receiving daily medication. A window in the health centre allows inmates to access nurses during out of cell hours.

1.5.3 Junee Correctional Centre

Junee CC is located in Junee approximately 400 kilometres south-west of Sydney. GEO operates the centre under private contract with CSNSW. The centre was built in 1993 and holds a maximum capacity of 1373 inmates. At the time of inspection, the centre accommodated a mixture of remand and sentenced inmates. The majority of these were inmates requiring protection from other inmates.

In the 2018 and 2019 calendar years, Junee CC had:[66]

2018	2019
• 959 new receptions • 896 movements out to court • 1742 transfers to the centre • 1064 inmates discharged from the centre	• 2,569 new receptions • 1,033 movements out to court • 1,259 transfers to the centre • 735 inmates discharged from the centre.

Table 1: Inmate statistics for Junee Correctional Centre in 2018 and 2019

Image 3: Aerial view of Junee Correctional Centre

At the time of inspection inmates were accommodated in four two-storey blocks each comprising four areas of 45 inmates per area. A separate accommodation area housing 140 minimum sentenced inmates comprising single-storey units opened onto a courtyard with shared kitchen, laundry and recreation areas. The centre had four beds for women however these were not occupied. At the time of inspection, around 28% of inmates identified as Aboriginal.

66 Information provided by CSNSW, 8 April 2019.

A stand-alone row of single storey rooms housed an offender services area, chapel, a TAFE campus, the health centre, a Learning Resource Centre (library) and a large industries area. At the time of inspection, 362 inmates were employed. The health centre operated seven days per week and had registered nurses on site 24 hours per day. The health centre was staffed by two enrolled nurses and two registered nurses on 12-hour shifts, one registered nurse on a 12-hour night shift, and an OST clerk. Specialty stream nurses in population health, metabolic monitoring, drug and alcohol, mental health and health promotion, work daytime 8-hour shifts from Monday to Friday, supervised by a full time Health Services Manager (equivalent to a NUM). A GP attended every week day; a psychiatrist attended 10 hours per fortnight; and a dentist, two days per week.

At the time of inspection, a construction of a new accommodation wing was underway, with upgrades of the health centre to follow. The expansion has added 480 maximum security beds with a 216-bed surge capacity and a new health centre.[67]

1.5.4 Shortland Correctional Centre

Shortland CC is a 713 bed facility located on the Cessnock Correctional Complex in the Hunter Valley approximately 150 kilometres north of Sydney. The centre holds a mixture of remand and sentenced maximum security inmates, as well as operating as a reception centre for the Hunter region.

At the time of inspection, the centre was known as Cessnock Correctional Centre Areas 3 and 4.[68] Maximum security inmates were held in two units of 128 beds each and an 80-bed VOTP High Intensity Programs Unit had just opened for inmates on the Violent Offender Therapeutic Program. Since then, the centre has expanded and has an additional 330 beds.[69]

The health centre is located adjacent to the reception wing and operates from 7:00am to 10:00pm. At the time of inspection, the health centre was staffed by 10.8 FTE nurses including a full time NUM. Specialty services included psychiatry once per week, a GP once per month, a population health nurse once per fortnight and drug and alcohol nurse on a weekly part-time basis. At the time of inspection, there were 20 inmates on OST and 11 inmates on supervised daily medication.

1.5.5 Cessnock Correctional Centre

Cessnock Correctional Centre is a 675 bed facility located on the Cessnock Correctional Complex in the Hunter Valley approximately 150 kilometres north of Sydney. At the time of inspection, the centre was known as 'Cessnock areas 1 and 2' and had capacity for 255 minimum and maximum sentenced beds and 155 minimum remand beds. Inmates were accommodated across four three-storey accommodation blocks of four wings each facing on to a central quadrangle accessible during out of cell hours. The centre also accommodated a small number of women in a single storey unit within the secure perimeter. A 30-bed unit for male minimum security inmates performing work in the community sits outside the secure perimeter.

At the time of the inspection, the health centre was adjacent to the reception office. Registered nurses were on-site from 7:00am until 9:00pm and nurses in population health, mental health and drug and alcohol, attended on a casual basis. A GP attended for five hours per week and a psychiatrist one day per week. There were 57 patients on OST and 25 inmates on supervised medication. Minimum security inmates had access to the clinic from 7:00am to 7:00pm and maximum-security inmates had access to the clinic from 9:30am to 3:00pm.

67 Information provided by CSNSW 4 February 2021.

68 Minister for Corrections (NSW), 'Crimes (Administration of Sentences) Act 1999' in New South Wales, *NSW Government Gazette,* No 52, 25 May 2018, 3095.

69 CSNSW, Prison Bed Capacity Program Delivery Report, 2020, p7.

Since that time the centre has expanded by 240 beds and a new health centre has been opened.[70]

Image 4: Cessnock Correctional Centre health centre

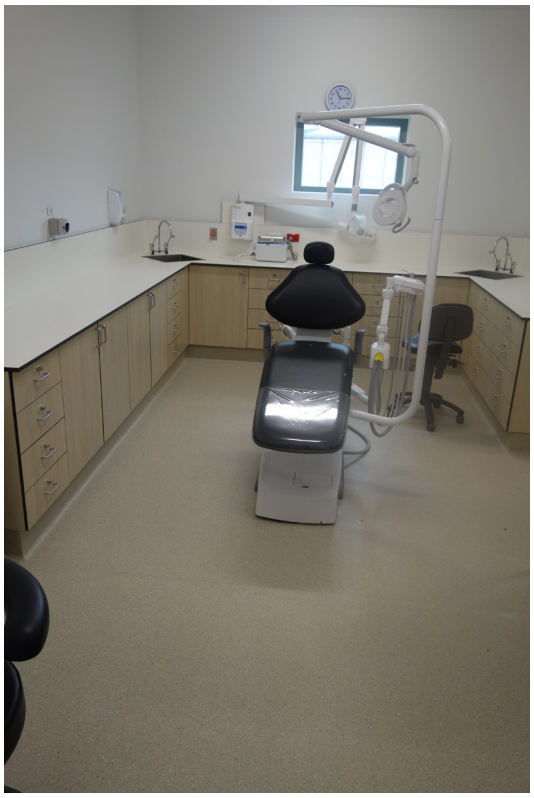

Image 5: Cessnock Correctional Centre health centre

70 CSNSW, Prison Bed Capacity Program Delivery Report, 2020, p7.

1.5.6 John Morony Correctional Centre, Windsor

John Morony Correctional Centre is located on the Francis Greenway Correctional Complex at Windsor, approximately 55 kilometres northwest of Sydney. The centre accommodates medium security remand inmates. The majority of inmates are housed in one of four two-storey wings which have 96 beds per unit.

Image 6: John Morony Correctional Centre entrance

The health centre is located in a building also containing programs and offender services staff, a library and activities rooms. The health centre is staffed from 6:00am to 10:00pm by a full time Nurse Unit Manager, full time health centre clerk, 6.12 FTE RNs, 1.4 ENs, part time mental health nurse, population health CNS, drug and alcohol CNS and clinical nurse educator. At the time of inspection, the health centre was funded for a full time Aboriginal health worker however this role was not filled. A dentist attends once per week, a psychiatrist two half days per week and a GP two days per week. Generally, the centre services 30 to 40 inmates on methadone, 0 to 8 on suboxone and 20 to 50 on supervised medication.

Chapter 2. The NSW Context

2.1 Standard of health care services

It is generally accepted in Australia (and broadly in international jurisdictions) that the standard of health care provided to inmates should be comparable to that available in the community.[71] The World Health Organisation notes 'there is a compelling interest on the part of society that [prisoners] receive health protection and treatment for any ill health'.[72] This is because the majority of prisoners return to the community after serving time on remand or a relatively short period of imprisonment.[73] Moreover, the recidivism rate in NSW means that many prisoners move between custody and the community a number of times.[74] This highlights the public health benefits of delivering effective health services in prisons.[75]

2.2 Responsibility for health care services

The *Crimes (Administration of Sentences) Act 1999* provides the legislative framework for the operation of NSW correctional facilities. Section 72A states:

> *An inmate must be supplied with such medical attendance, treatment and medicine as in the opinion of a medical officer is necessary for the preservation of the health of the inmate, of other inmates and of any other person*.[76]

The health care of people incarcerated in NSW correctional facilities is the responsibility of the State through the NSW Ministry of Health.[77] Justice Health & Forensic Mental Health Network (JH&FMHN) is a specialty network governed statutory health corporation within the NSW public health system under the *Health Services Act 1997*. The core function of JH&FMHN is 'delivering health care to adults and young people in contact with the forensic mental health and criminal justice systems, across community, inpatient and custodial settings'.[78]

JH&FMHN provides health services to inmates in the vast majority of NSW correctional centres[79] (at 33 of the 36 correctional centres in NSW as at September 2020).[80] JH&FMHN must provide services 'in a manner consistent with all NSW Health policies, procedures, plans, circulars, inter-agency agreements, Ministerial directives and other instruments.[81]

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71 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), GA Res 70/175, UN Doc A/RES/ 54/254 (8 January 2016, adopted 17 December 2015) rule 24(1)'.

72 World Health Organisation: Regional Office for Europe, *Prisons and Health* (Report, 2014) 2.

73 Australian Bureau of Statistics, *Prisoners in Australia, 2019* (Catalogue No 4517.0, 5 December 2019) Tables 27 and 32; see also Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) vi.

74 Approximately 53.46% of adult inmates have been imprisoned on a prior occasion. See Australian Bureau of Statistics, *Prisoners in Australia, 2019* (Catalogue No 4517.0, 5 December 2019) Table 29. In 2017, approximately 40.7% of adult inmates exiting prisons in NSW, re-offended within 12 months; 'Re-offending Statistics for NSW', *New South Wales Bureau of Crime Statistics and Research* (Web page) <https://www.bocsar.nsw.gov.au/Pages/bocsar_pages/Re-offending.aspx>.

75 Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) vi.

76 *Crimes (Administration of Sentences) Act 1999* s 72A.

77 Section 19(2) of the *Health Insurance Act 1973* (Cth) provides that health services are not eligible for Medicare benefit if the services are provided by state or territory governments. See also Department of Health (NSW), *2018-19 Service Agreement: An Agreement Between Secretary, NSW Health and the Justice Health and Forensic Mental Health Network* (29 November 2018) 4: 'Commonwealth legislation provides that all persons on remand and convicted prisoners are ineligible to use their Medicare card for the purposes of accessing public health services whilst in custody, as prisoner health care is the responsibility of State and Territory Governments.'

78 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 5.

79 Justice Health and Forensic Mental Health Network, *Our Network 2019* (NSW Department of Health, December 2019) 7.

80 Information provided by CSNSW September 2020.

81 Department of Health (NSW), *2018-19 Service Agreement: An Agreement Between Secretary, NSW Health and the Justice Health and Forensic Mental Health Network* (29 November 2018) 5.

All services of JH&FMHN have full accreditation under the Australian Commission on Safety and Quality in Health Care's *National Safety and Quality Health Service (NSQHS) Standards*[82] and the Royal Australian College of General Practitioners' *Standards for Health Services in Australian Prisons.*[83]

The JH&FMHN board is the primary clinical governance body oversighting JH&FMHN services.[84]Through its Health Care Quality Committee the Board receives assurance of clinical governance by receiving and reviewing reports on:

- Governance, leadership and culture
- Patient safety and quality improvement systems
- Clinical performance and effectiveness
- Safe environment for the delivery of care
- Partnering with consumers.

The functions of JH&FMHN in NSW correctional facilities are provided for under section 236A of the *Crimes (Administration of Sentences) Act 1999*:

Justice Health,[85] in addition to any other functions conferred on it by or under this or any other Act or law, has the following functions:

(a) to provide health services to offenders and other persons in custody within the meaning of section 249,[86]

(b) to monitor the provision of health services in managed correctional centres,

(c) to prevent the spread of infectious diseases in, or in relation to, correctional centres,

(d) to keep medical records of offenders and other persons in custody within the meaning of section 249,

(e) to provide advice to the Commissioner on the diet, exercise, clothing, capacity to work and general hygiene of inmates.[87]

Under the Act, the CEO of JH&FMHN may have unfettered access to all parts of correctional centres, including all offenders and all medical records.[88]

The *Crimes (Administration of Sentences) Act 1999* provides for the operation of private prisons:

82 The Long Bay Hospital and Forensic Hospital will be re-accredited against these standards in November 2019. See 'Australian Health Service Safety and Quality Accreditation Scheme', *Australian Commission on Safety and Quality in Health Care* (Web Page) <https://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/>; ' The NSQHS Standards', *Australian Commission on Safety and Quality in Health Care* (Web Page) <https://www.safetyandquality.gov.au/standards/nsqhs-standards>.

83 The Royal Australian College of General Practitioners, *Standards for Health Services in Australian Prisons* (1st ed, April 2011). Information provided by JH&FMHN 21 February 2021.

84 Information provided by JH&FMHN September 2020; Network Board committee structure diagram; Model by-laws; Network Health Care Quality Committee Terms of Reference; Network Attestation – compliance with responsibilities under the National Safety and Quality Health Service Standards.

85 The name of this organisation has since been changed to Justice Health and Forensic Mental Health Network in 2011, 'as part of the national health and hospitals reforms and was renamed to reflect the service as a specialty network'; see 'Our History: Origins', *NSW Government Health: Justice Health and Forensic Mental Health Network* (Web page) <https://www.justicehealth.nsw.gov.au/about-us/jh-fmhn-history>.

86 Section 249 of the *Crimes (Administration of Sentences) Act 1999* provides definitions for 'persons in custody'.

87 See also *Crimes (Administration of Sentences) Regulation 2014 clauses 285 and 287.*

88 Section 236B *Crimes (Administration of Sentences) Act 1999*.

238(1) The Commissioner may enter into an agreement (the ***management agreement***) with a corporation (the ***management company***) providing for the management of one or more correctional centres.

The delivery of health services by private or sub-contracted service providers is monitored by JH&FMHN. In 2018, JH&FMHN developed a governance and monitoring framework for fulfilling this legislative requirement.[89] The responsibility for clinical governance sits appropriately with the private or sub-contracted health services.

2.3 Health status and needs of NSW inmates

The NSW prison population has numerous and complex health needs, and typically minimal contact with health services in the community prior to entering custody.[90] This health profile informs the range of services offered in custody and places significant demand upon these services.

Incarcerated people have poorer health compared to the broader community.[91] They experience higher rates of communicable disease, chronic illness, substance misuse, and dual diagnoses of mental health issues and physical or other health problems.[92] They are also more likely to have experience of mental health issues including anxiety, depression, post-traumatic stress disorder, psychosis and suicidal thoughts.[93] This is influenced by the overrepresentation of lower socio-economic status groups in custody.[94] These groups are structurally disadvantaged in accessing the social determinants of health, including education, secure housing and/or community support.[95] Further, incarceration itself is associated with a range of negative health outcomes.[96]

2.3.1 General population

In 2015, JH&FMHN undertook a *Network Patient Health Survey* (NPHS), interviewing a representative sample of male and female inmates across NSW correctional centres.[97] The purpose of the survey is to provide an 'epidemiological snapshot' every five years to inform service delivery, planning, and optimise resources.[98] The 2015 survey is the fourth survey undertaken by JH&FMHN.[99] The results 'visibly demonstrate[d] the higher levels of socioeconomic disadvantage and complex health needs' of their population. In reviewing the findings of the NPHS, it is important to note that approximately 93% of the NSW adult prison population is male and statistics may vary with gender.[100] Survey respondents reported the following:

89 Information provided by JH&FMHN 2018.

90 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 6, 14.

91 Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) vi.

92 Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) vi, 49; The Royal Australian College of General Practitioners, *Standards for Health Services in Australian Prisons* (1st ed, April 2011) 2-3 ; Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 14.

93 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 52-62.

94 The *2015 Network Patient Health Survey Report* demonstrates disadvantage in a range of social determinants of health including experiences of out of home care (page 24), parental incarceration (page 25), education (pages 25-26), employment status (page 28), housing (page 27); see also Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) 13-25, 43.

95 The NSW Agency for Clinical Innovation Website defines the social determinants of health and the link between poor health and socio-economic disadvantage. See 'Chronic Care Network: Social Determinants of Health', *NSW Government: Agency for Clinical Innovation* (Web page). <https://www.aci.health.nsw.gov.au/resources/chronic-care/social-determinants-of-health/sdoh/about>.

96 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 82.

97 See Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017).

98 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 14.

99 See Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 11.

100 As of the third quarter of 2019, there were a total of 12551 male and 971 female inmates in adult custody according to 'Custody Statistics: Custody Reports', *NSW Bureau of Crime Statistics and Research* (Web page, updated as at 6 November 2019) <https://www.bocsar.nsw.gov.au/Pages/bocsar_custody_stats/bocsar_custody_stats.aspx>.

- 20.7% had been diagnosed with Hepatitis C
- 15.6% had been diagnosed with high blood pressure
- 20.3% experienced drug abuse or dependence
- 67.1% of men and 63.3% of women indicated hazardous levels of drinking prior to custody
- 62.9% of participants had previously received a diagnosis of mental illness
- 49.2% of participants had received some form of psychiatric care prior to incarceration
- 65.2% had experienced or witnessed at least one traumatic event
- 18% had previously attempted suicide (10 times higher than the community rate)
- 27.1% had three or more health conditions

A 2003 report by Butler and Allnutt *found that almost half of reception (46%) and over one-third (38%) of sentenced inmates had suffered a mental disorder (psychosis, affective disorder, or anxiety disorder) in the previous twelve months.*[101]

Research published in 2013 found that 77 per cent of prisoners in NSW had a mental health problem.[102] The very high prevalence of mental health problems as distinct from mental illness, reported among prisoners includes diagnoses of substance abuse disorder, personality disorder, anxiety and depression. The NSW Mental Health Commission view is that a history of trauma and/or mental illness among NSW prisoners should be regarded as 'the norm'.[103]

The NPHS Survey also revealed a hesitation among inmates to access health services, with 45.6% reporting a strong reluctance to attend a health clinic, and 2.9% unwilling to access health care at all.[104] Only 31.3% had seen a GP in the community in the last 12 months, which increased to 56% seeing a GP once incarcerated.[105]

2.3.2 Dental

Dental health is a particular area of concern among inmates.[106] Disadvantage in the social determinants of health combined with the prevalence of substance misuse, results in a concentration of poor oral health among this cohort.[107] The 2015 NPHS found 36% of respondents reported tooth decay. Inmates are also less likely to have accessed oral health services in the community.[108] Of all respondents, 56% had not received treatment in more than 12 months, while 5.2% had never received any dental treatment.[109]

101 Butler and Allnutt, *Mental Illness among New South Wales Prisoners,* August 2003.

102 Ruth McCausland, et al, 'People with Mental Health Disorders and Cognitive Impairment in the Criminal Justice System: Cost-Benefit Analysis of Early Support and Diversion' (Report, August 2013) 4.

103 Mental Health Commission of New South Wales, *Inside Outside: Recovery Research Project: A Discussion Paper by the Mental Health Commission of New South Wales* (Discussion Paper, July 2017) introduction.

104 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 43.

105 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 43.

106 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 44.

107 The prevalence of dental cavities and periodontal disease is higher among substance misusers than in the general population. See World Health Organisation, *Prisons and Health*, 2014, pp99-100

108 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 44-5.

109 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 45.

2.3.3 Chronic health

The prevalence of chronic health or debilitating conditions among NSW inmates is represented in the table below, which shows proportions of each condition among the total sample of 2015 *Network Patient Health Survey* respondents at the time of interview:[110]

Table 2: Prevalence of chronic health conditions

	Males	Females	Total
Allergies	15.1%	30.0%	16.1%
Arthritis	10.4%	17.4%	10.9%
Asthma	15.2%	33.3%	16.4%
Back problems	21.3%	28.6%	21.8%
Cancer/tumours	2.6%	2.4%	2.6%
Diabetes	4.9%	6.3%	5.0%
Epilepsy/seizures	1.9%	4.4%	2.1%
Chest pain/angina	5.8%	8.8%	6.0%
High blood pressure	11.7%	9.1%	11.6%
Stroke	0.8%	0.2%	0.8%
Heart disease/condition	4.1%	4.5%	4.1%
Hepatitis A	0.3%	0.2%	0.3%
Hepatitis B	1.5%	1.5%	1.5%
Hepatitis C	13.2%	18.4%	13.6%
Liver disease	1.8%	3.5%	1.9%
Kidney disease	1.6%	2.5%	1.6%
Prostate problems	1.3%	-	1.2%

Chronic conditions may be particularly difficult to manage in custody for both inmates and health care providers. Regular monitoring of chronic conditions is required to avoid deterioration, and the ability to monitor may be impacted by inmates' ability to access the health centre, and the demand for such services in custody.

Additionally, particular groups within the inmate population have specific health needs.[111] These are outlined below to demonstrate the significant challenges inherent to health service delivery in correctional environments.

2.3.4 Women

Women make up around 7.2 per cent of the NSW prison population as of September 2019.[112] While there are smaller numbers of women in the custodial system, they often present with 'more complex needs' than

110 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 35.

111 'The Justice System', *Mental Health Commission of New South Wales* (Web page, 17 September 2014) <https://nswmentalhealthcommission.com.au/mental-health-and/the-justice-system#inadequate>.

112 'Custody Statistics: Custody Reports', *NSW Bureau of Crime Statistics and Research* (Web page, updated as at 6 November 2019) <https://www.bocsar.nsw.gov.au/Pages/bocsar_custody_stats/bocsar_custody_stats.aspx>.

men, 'including those related to mental health'. [113]

Regular screening for cervical cancer is a key health need for female inmates.[114] JH&FMHN have internal KPIs in relation to the number of patients receiving a cervical screen, breast screen, mammogram and pap smears.[115] While breast cancer is a common cancer diagnosis among women in general, there are few incarcerated women within the age range eligible for regular mammography (50 to 69 years).[116]

Female inmates also have specific health needs in relation to pregnancy.[117] 85.5% of female respondents to the NPHS had been pregnant at least once.[118] The median age at the time of birth was 19, compared to the community median of 30 years.[119] Three quarters of respondents had given birth by the age of 22, compared to the majority of births in the community occurring between the ages of 30 to 34 years.[120] These differences are significant because pregnancy for younger women is associated with poor health outcomes for both mother and baby.[121] The survey also found that 48.8% of women interviewed reported a miscarriage and 44.2% reported having undergone at least one termination.[122] These rates of miscarriage and pregnancy termination warrant specific and specialist support for women in custody who experience pregnancy loss.

Women in custody in NSW generally report more mental health needs than their male counterparts. They also have higher rates of diagnosis for depression, anxiety, drug abuse, bipolar disorder, and personality disorder than male inmates.[123] JH&FMHN found that 43.3% of female inmates reported suicidal ideation, compared to 29.6% of males.[124] Women were also more likely to report self-harming behaviour 24.6%, compared to 10.9% of men.[125] This highlights the complexity of the needs of women as well as the need for access to psychiatry and specialist mental health care that is appropriate and tailored for the needs of women.

Some male correctional centres have a small women's unit attached. Women held in these units are often in transit between centres but may remain for extended periods. Access to women's specialist health services can be a challenge in these circumstances.[126] The health needs of female inmates is discussed in the ICS report on women on remand in NSW correctional centres.[127]

113 Mental Health Commission of New South Wales, *Living Well: A Strategic Plan for Mental Health 2014-2024*, (2014) 82.

114 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 41.

115 Information provided by JH&FMHN on 18 February 2019.

116 Women between the ages of 50 and 69 are eligible to participate in a government-funded mammography program. See Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 41.

117 Australian Institute of Health and Welfare, *The Health of Australia's Prisoners 2015* (2015) 75.

118 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 42.

119 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 42.

120 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 42.

121 Australian Institute of Health and Welfare, *The Health of Australia's Prisoners 2015* (2015) 75.

122 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 42-43.

123 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 53.

124 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 60.

125 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 61.

126 Interviews with staff 2018.

127 Inspector of Custodial Services (NSW), 'Women on Remand' (Report, February 2020).

2.3.5 Aboriginal inmates

Aboriginal people make up approximately 23.1 per cent of people incarcerated in NSW correctional centres, and 3 per cent of the NSW population.[128]The existence of a national strategy called 'Closing The Gap' with targets in health, education, mortality and justice demonstrates the burden of disadvantage among Aboriginal people.[129] It also reflects that the Aboriginal and Torres Strait Islander burden of disease is 2.3 times greater than the non-Indigenous burden in the general population.[130] Chronic health issues are also overrepresented among Aboriginal people.[131]

Incarcerated Aboriginal people are therefore a particularly vulnerable prison sub-population in terms of health need.[132] JH&FMHN's 2015 *Aboriginal Peoples Health Report* identified the 'markedly divergent' health needs of Aboriginal inmates compared to non-Aboriginal, and found that Aboriginal participants reported higher instances of schizophrenia, psychosis, alcohol abuse or dependence, and post-traumatic stress disorder compared to non-Aboriginal patients.[133] Aboriginal women in particular are known to have the highest rate of social and emotional wellbeing issues of any group of inmates.[134]

This highlights the need for and importance of specialist, culturally appropriate medical interventions and support for Aboriginal people, noting that the needs of Aboriginal women differ from Aboriginal men (and non-Aboriginal women).[135]

Aboriginal people may also be less likely to access healthcare in the community or custody. This is often due to a complex mix of factors including structural disadvantage and experiences of racism in contacts with mainstream institutions.[136] The current *NSW Aboriginal Health Plan* acknowledges that:

> *the consequences of colonisation, which have had a devastating impact on the social, economic and physical living conditions of Aboriginal people for over 200 years — directly contribute to the health disparities experienced by many Aboriginal people*[137]

The health needs of Aboriginal people should be considered in terms of Aboriginal understandings of health and wellbeing. The *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* defines this as:[138]

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128 Australian Bureau of Statistics, *Prisoners in Australia, 2019* (Catalogue No 4517.0, 5 December 2019) *Table* 15; CSNSW, Indigenous stats August 1 2018; Australian Bureau of Statistics - Estimates of Aboriginal and Torres Strait Islander Australians, June 2016 http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001#

129 'Closing the Gap', *National Indigenous Australians Agency* (Web page) <https://www.niaa.gov.au/indigenous-affairs/closing-gap>.

130 Australian Medical Association, *2018 Australian Medical Association Report Card on Indigenous Health* (November 2018) 5.

131 Edith Cowan University, *Summary of Aboriginal and Torres Strait Islander health status 2019*, 15 June 2020, pp. 1-37. https://healthinfonet.ecu.edu.au/learn/health-facts/summary-aboriginal-torres-strait-islander-health/40279/?title=Summary%20of%20Aboriginal%20and%20Torres%20Strait%20Islander%20health%20status%202019&contentid=40279_1

132 Justice Health and Forensic Mental Health Network, 'Network Patient Health Survey: Aboriginal People's Health Report 2015' (Report, Department of Health (NSW), November 2017) 1, 41.

133 Justice Health and Forensic Mental Health Network, 'Network Patient Health Survey: Aboriginal People's Health Report 2015' (Report, Department of Health (NSW), November 2017) xiii, 41.

134 'The Justice System', *Mental Health Commission of New South Wales* (Web page, 17 September 2014) <https://nswmentalhealthcommission.com.au/mental-health-and/the-justice-system#inadequate>; Butler et al Australian and New Zealand Journal of Psychiatry 2007; 41:429-435 compared mental health of Aboriginal and non-Aboriginal prisoners in NSW and found: No differences were detected in mental illness between Aboriginal and non-Aboriginal men, apart from depression, which was lower in the latter group. Aboriginal women were more likely than non-Aboriginal women to screen positive for symptoms of psychosis in the prior 12 months and have a higher one month and 12 month prevalence of affective disorder; they also had a higher psychological distress scores. Suicidal thoughts and attempts were the same in both groups.

135 *Kariminia, A., Butler, T. and Levy M. in a paper published in the Australian and New Zealand Journal of Public Health 2007 vol. 31 no. 4*.

136 Justice Health and Forensic Mental Health Network, *NSW Inmate Health Survey*: *Aboriginal Health Report*, (2009) 65; Gavin Mooney, 'Institutionalised Racism in Australian Public Services' (2003) 5(26) *Indigenous Law Bulletin* 10, 10-1; 'Cultural Safety Crucial in Aboriginal and Torres Strait Islander Heath Care', *Australian Healthcare and Hospitals Association: The Voice of Public Health Care* (Blog, 26 March 2018) <https://ahha.asn.au/news/cultural-safety-crucial-aboriginal-and-torres-strait-islander-healthcare>.

137 Department of Health (NSW), *NSW Aboriginal Health Plan 2013-2023* (December 2012) 3.

138 *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*(5 July 2018) 9. <https://www1.health.gov.au/internet/main/publishing.nsf/Content/natsih-plan>.

[..] not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community[139]

2.3.5.1 The importance of culturally safe primary health care

Culturally safe primary health care is key to meeting the health and wellbeing needs of Aboriginal people, and to improve the accessibility of health care for this group.[140] Culturally safe primary health care is:

> *somewhat broader in scope than most other primary health care models in Australia. In addition to primary clinical care and preventive and health promotion activity, Aboriginal Community Controlled Health Services usually include education and development in relation to workforce training, and governance and community capacity building […] The provision of this calibre of health care requires an intimate knowledge of the community and its health problems.*[141]

The importance of culturally safe primary health care was recognised (though in different terminology) in 1991 by the Royal Commission into Aboriginal Deaths in Custody which recommended:

> *That Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review […]*
>
> *b. The extent to which services provided are culturally appropriate for and are used by Aboriginal inmates. Particular attention should be given to drug and alcohol treatment, rehabilitative and preventative education and counselling programs for Aboriginal prisoners. Such programs should be provided, where possible, by Aboriginal people;*
>
> *c. The involvement of Aboriginal Health Services in the provision of general and mental health care to Aboriginal prisoners […]*[142]

NSW has a strong policy framework recognising the importance of culturally safe primary health care. The NSW *Aboriginal Health Plan 2013-2023* states:

> *In every part of the health system in NSW, there needs to be a focus on Aboriginal people, services that are delivered in a culturally competent and safe manner, and where required, services tailored to meet the unique and local needs of Aboriginal communities.*[143]

139 This definition was first established in the National Aboriginal Health Strategy 1989; see National Aboriginal Health Strategy Working Party, *A National Aboriginal Health Strategy* (1989) cited in Department of Health (Cth), *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (5 July 2018) 9 <https://www1.health.gov.au/internet/main/publishing.nsf/Content/natsih-plan>.

140 The Lowitja Institute, *National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care 2015-2025* (November 2015) 5'Cultural Safety Crucial in Aboriginal and Torres Strait Islander Heath Care', *Australian Healthcare and Hospitals Association: The Voice of Public Health Care* (Blog, 26 March 2018) <https://ahha.asn.au/news/cultural-safety-crucial-aboriginal-and-torres-strait-islander-healthcare; CATSINaM *Position statement, p1.3*; 'Removing the Barriers to Indigenous Health - Strategies to Improve Access', *Australian Medical Association* (Blog post, 16 September 2012).

141 The Lowitja Institute, *National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care 2015-2025* (November 2015) 25.

142 *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) vol 3, recommendation 152.

143 Department of Health (NSW), *NSW Aboriginal Health Plan 2013-2023* (December 2012) 9.

Principles of the Plan reflect the centrality of culture:

1. Trust and cultural respect.
2. Recognition of the cultural values and traditions of Aboriginal communities.
3. Holistic approaches to the health of Aboriginal people.
4. The valuable and unique role of ACCHSs.[144]
5. The participation of Aboriginal people at all levels of health service delivery and management.
6. Partnership with Aboriginal communities through ACCHSs and the AH&MRC.
7. Recognition of the contribution the health system can make to the social determinants of health. [145]

JH&FMHN as a specialty network within NSW Health is responsible and accountable for implementing the *Plan.* It is also a member of the NSW Aboriginal Health Plan Working Group.[146] JH&FMHN's *Strategic Plan 2018 – 2022* contains strategic directions specifically in relation to Aboriginal health. These are to deliver culturally responsible care to improve the health status of Aboriginal patients, and to target expansion of the clinical and non-clinical Aboriginal workforce.[147] Engagement with Aboriginal Community Controlled Health Organisations is also noted in the Plan.[148]

2.3.6 Aged inmates

Prisoners experience 'accelerated ageing', where signs of ageing may occur 10 to 15 years earlier than for the rest of the population.[149] JH&FMHN and CSNSW define aged inmates as those over 55 years for non-Aboriginal people and over 45 years for Aboriginal people.[150]

The numbers of aged inmates in custody has increased disproportionately compared to community demographics.[151] In 2015, this office noted a 225 per cent increase in the number of male inmates over 65 years in the period 2010 – 2015. The numbers of aged inmates in the NSW correctional system rose overall between 2015 and 2019, as represented below:

Table 3: Numbers of elderly and aged inmates in CSNSW centres 2015-2019

	2015	2016	2017	2018	2019
Non-Aboriginal (55yrs+)	922	1003	1112	1175	1126
Aboriginal (45yrs+)	351	390	448	550	467

Source: CSNSW August 2020. Numbers based on census dates of 30th June of the relevant year

Older inmates often have complex needs relating to health, decreased physical capacity and increased

144 An Aboriginal Community Controlled Health Organisation or Service (ACCHO) is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community that controls it, through a locally elected Board of Management; see 'Home: Aboriginal Health in Aboriginal Hands', *NACCHO* (Web page) <https://www.naccho.org.au/>

145 Department of Health (NSW), *NSW Aboriginal Health Plan 2013-2023* (December 2012) 4.

146 The Group also includes the NSW Ministry of Health, AH&MRC, and NSW LHDs. See Department of Health (NSW), *NSW Aboriginal Health Plan 2013-2023* (December 2012) 4, 7.

147 See outcomes 1.1 (d) and 3.3 (c) in Justice Health and Forensic Mental Health Network, *Strategic Plan 2018-2022* (December 2017) 22, 26.

148 Justice Health and Forensic Mental Health Network, *Strategic Plan 2018-2022* (December 2017) 31.

149 Australian Institute of Health and Welfare, *Australia's Health 2018* (Australia's Health Series No 16, 20 June 2019) 302.

150 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 14; CSNSW data provided on 6 December 2018.

151 Efty Stavrou, 'Changing Age Profile of NSW Offenders' (NSW Bureau of Crime Statistics and Research, Issue Paper No 123, March 2017) 1.

vulnerability.[152] This includes deteriorating cognition, higher rates of sub-acute chronic conditions requiring regular monitoring, and increased risk of falls due to frailty.[153] Alzheimer's, dementia, other cognitive disabilities and hearing loss may present extra challenges in the prison environment. Behavioural symptoms may be incorrectly interpreted as non-compliance, or leave inmates open to exploitation by other inmates.[154] Symptoms can also go unnoticed altogether, which means the need for appropriate support and care may not be identified.[155] Further, while prison food meets basic nutritional standards, it may not meet all the required variations older prisoners require due to their frailty and health issues, such as diabetes and dysphagia.[156] Specialised services are therefore provided.

Recent literature argues Australian prison environments need to better accommodate the limited mobility and cognitive capacity of older inmates through infrastructure and staff training.[157] Multidisciplinary care plans involving health and custodial staff are required to meet the needs of aging inmates.[158] In 2015, the ICS report *Old and Inside* found that 'current levels of service provision do not meet demand for aged-care services, including optometry, podiatry, aged-care psychiatry and geriatrician services'.[159]

2.3.7 Inmates with disability

Disability and health are mutually informing.[160] In general, people living with a disability have poorer health than those without.[161] The exact prevalence of disability among incarcerated populations is difficult to measure.[162] In 2015, JH&FMHN found 27.8% of NPHS respondents could be considered to have a disability impacting mobility, cognition, communication, or self-care.[163] An absence of appropriate services to support their needs in the community may contribute to some people with a cognitive disability coming into custody.[164] Further, some may find it difficult to cope with or adhere to correctional centre routine, may be less able to advocate for themselves, and may be at risk from other prisoners.

Research regarding Indigenous prisoners with cognitive disability found that while diagnosis of a cognitive disability often occurs following assessment upon reception into prison, it may not equal adequate support while in custody.[165]

152 Efty Stavrou, 'Changing Age Profile of NSW Offenders' (NSW Bureau of Crime Statistics and Research, Issue Paper No 123, March 2017) 1.

153 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 14.

154 Alzheimer's Australia, *Dementia In Prison* (Discussion Paper No 9, March 2014) 6; Gary Forrest et al, *Previously Unrecognised Issues: Managing the Health of an Ageing Prison and Homeless Population* in Maree Bernoth and Denise Winkler (eds) *Healthy Ageing and Aged Care* (Oxford University Press, 1st ed, 2016) 225.

155 Alzheimer's Australia, *Dementia In Prison* (Discussion Paper No 9, March 2014) 6; Gary Forrest et al, *Previously Unrecognised Issues: Managing the Health of an Ageing Prison and Homeless Population* in Maree Bernoth and Denise Winkler (eds) *Healthy Ageing and Aged Care* (Oxford University Press, 1st ed, 2016) 225.

156 Gary Forrest et al, *Previously Unrecognised Issues: Managing the Health of an Ageing Prison and Homeless Population* in Maree Bernoth and Denise Winkler (eds) *Healthy Ageing and Aged Care* (Oxford University Press, 1st ed, 2016) 225.

157 Natasha A Ginnivan, Tony G Butler and Adrienne N Withall, 'The Rising Health, Social and Economic Costs of Australia's Ageing Prisoner Population' (2018) 209(10) *Medical Journal of Australia* 422.

158 Gary Forrest et al, *Previously Unrecognised Issues: Managing the Health of an Ageing Prison and Homeless Population* (Oxford University Press, 1st ed, 2017), in Bernoth, M. and Winkler, D. (eds.) *Healthy Ageing and Aged Care, 2016,* p225

159 Inspector of Custodial Services (NSW), *Old and Inside: Managing Aged Offenders in Custody* (September 2015) 11.

160 Australian Institute of Health and Welfare, *Australia's Health 2018: In brief* (20 June 2018) 36.

161 Australian Institute of Health and Welfare, *Australia's Health 2018: In brief* (20 June 2018) 36.

162 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 83.

163 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 47; CSNSW advise that 3% of the adult custodial population had an IQ in the range of intellectual disability. Information provided by CSNSW 4 February 2021.

164 Eileen Baldry, Ruth McAusland and Elizabeth McEntyre, 'Indigenous People, Mental Health, Cognitive Disability and the Criminal Justice System' (Indigenous Justice Clearinghouse, Brief 22, August 2017) 2-3.

165 Eileen Baldry, Ruth McAusland and Elizabeth McEntyre, 'Indigenous People, Mental Health, Cognitive Disability and the Criminal Justice System' (Indigenous Justice Clearinghouse, Brief 22, August 2017) 2, 4.

Prisoners with cognitive disability can have complex support needs, meaning they require long term, coordinated support across mental health, drug and alcohol use, and other behavioural problems.[166] Currently these service areas are delineated as separate clinical streams within the comprehensive model of offender health delivered in NSW correctional centres. There are no specific services within this model for inmates with disability.

CSNSW Statewide Disability Services in conjunction with JH&FMHN are the primary services for meeting the needs of people with a cognitive disability in custody. In addition, the CSNSW Personality and Behavioural Disorder service also assists inmates with a cognitive disability. Three Additional Support Units (ASUs) located at the Long Bay Correctional Complex accommodate inmates with cognitive impairment.[167] Inmates in the ASUs may receive further assessment, programs to address offending behaviour, skills development, employment opportunities, case management and release planning.[168] The introduction of the NDIS has potential to provide inmates with disabilities with better throughcare and support. This may reduce the risk of recidivism for some people with intellectual disabilities, upon their release from custody.

2.3.8 Inmates with complex comorbidities

Comorbidity refers to the coexistence of mental health and substance use disorders. A 2011 study of Australian prisoners found inmates have a high prevalence of co-occurring substance use and mental illness compared to community rates.[169] Similarly, 46.1% of 2015 JH&FMHN Patient Health Survey participants reported diagnosis of two or more chronic illnesses, and 47% of participants reported having been diagnosed with two mental illnesses.[170]

Chronic and comorbid conditions can be mutually informing. Evidence shows that risk of chronic physical disease increases for people with severe and persistent mental illness.[171] Similarly, oral diseases are overrepresented among populations experiencing disadvantage and mental illness.[172] This is significant for prison health services as these groups are overrepresented in prison. Further, people with co-occurring disorders are more likely than people with a single disorder to have poor health, respond poorly to treatment, be less compliant with treatment, and be in contact with the criminal justice system.[173]

A study of 1200 inmates in New Zealand identified the importance of integrated and concurrent treatment of mental health and substance abuse for improvements in health and reduction in recidivism.[174] This is supported by Australian literature suggesting prisoners with comorbidities should be prioritised for targeted interventions coordinated across service areas.[175]

166 Dr Lauren Costello, Dr Melanie Thomson and Dr Katie Jones for the Mental Health Commission of New South Wales, 'Mental Health and Homelessness Final Report' (Final Report, June 2013) 12.

167 'Services for Inmates with a Disability', *NSW Government: Communities and Justice* (Web page) <https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/programs/statewide-disability-services/statewide-disability-services.aspx>.

168 'Services for Inmates with a Disability', *NSW Government: Communities and Justice* (Web page) <https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/programs/statewide-disability-services/statewide-disability-services.aspx>.

169 Tony Butler et al, 'Co-occuring Mental Illness and Substance Use Disorder Among Australian Prisoners' (2011) 30(2) *Drug and Alcohol Review* 188.

170 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 82.

171 Mental Health Commission of New South Wales, *Physical Health and Mental Wellbeing: Evidence Guide* (2016) 10; Tony Butler et al, 'Co-occuring Mental Illness and Substance Use Disorder Among Australian Prisoners' (2011) 30(2) *Drug and Alcohol Review* 188.

172 Mental Health Commission of New South Wales, *Physical Health and Mental Wellbeing: Evidence Guide* (2016) 24.

173 Tony Butler et al, 'Co-occurring Mental Illness and Substance Use Disorder Among Australian Prisoners' (2011) 30(2) *Drug and Alcohol Review* 188.

174 Devon Indig et al, 'Comorbid Substance Use Disorders and Mental Health Disorders among New Zealand Prisoners' (New Zealand Department of Corrections, 2016) 77-8.

175 Tony Butler et al, 'Co-occurring Mental Illness and Substance Use Disorder Among Australian Prisoners' (2011) 30(2) *Drug and Alcohol Review* 188.

2.4 Delivery of Health Services

The health needs of prisoners in NSW requires a broad scope of practice and service provision by prison health service providers, across primary health, mental health, drug and alcohol, public health and women's health. In line with this range of demands, a comprehensive range of services are delivered across a number of clinical streams in NSW prisons.

This report refers to this model as the 'comprehensive offender health model'. This model involves:

- **Primary health** services provided in 'health centres', which are stand-alone areas within correctional centres, staffed by registered nurses. This is a nurse dominated model, supported by visiting General Practitioners and Nurse Practitioners (NPs) (in limited locations). After hours support where required occurs through an on-call service to an after hours Nurse Manager or a GP. The private or sub-contracted health providers may use a different model. A Nurse Unit Manager (NUM) is responsible for overseeing service delivery, operations, reporting and recruitment. Some NUMs will also have clinical duties. Health centres exist in every correctional centre in NSW. The size and staffing complement of each health centre varies between centres. There is no resource distribution formula (currently nor historically), however factors influencing health centre resourcing include overall inmate numbers, whether the prison has remand and reception functions, the rate of inmate turnover (numbers of inmates received for short stays), and security classifications.

- **Secondary** specialist care is available via in-reach services (clinicians visiting correctional centres), or through facilitation of outpatient appointments in community Local Health Districts (LHDs). The majority of specialist appointments are booked at the Prince of Wales Hospital, Randwick.[176] Outpatient or specialist services at LHDs should not be used routinely, except for diagnostic medical imaging and emergency department services.[177] Inmates may access private health services at their own expense for the purposes of gaining a second opinion, continuing treatment with a private provider previously commenced in the community or for a non-urgent surgical procedure.[178]

- **Tertiary** care in specialised inpatient facilities is available at the Long Bay Hospital (LBH) and a Secure Annex within the Prince of Wales Hospital, Randwick, both of which are gazetted correctional facilities. Local public hospitals are utilised for acute and critical care, and in emergencies, under custodial supervision. Transfer and referrals between JH&FMHN and LHDs for secondary or tertiary services occur according to NSW Health policy.

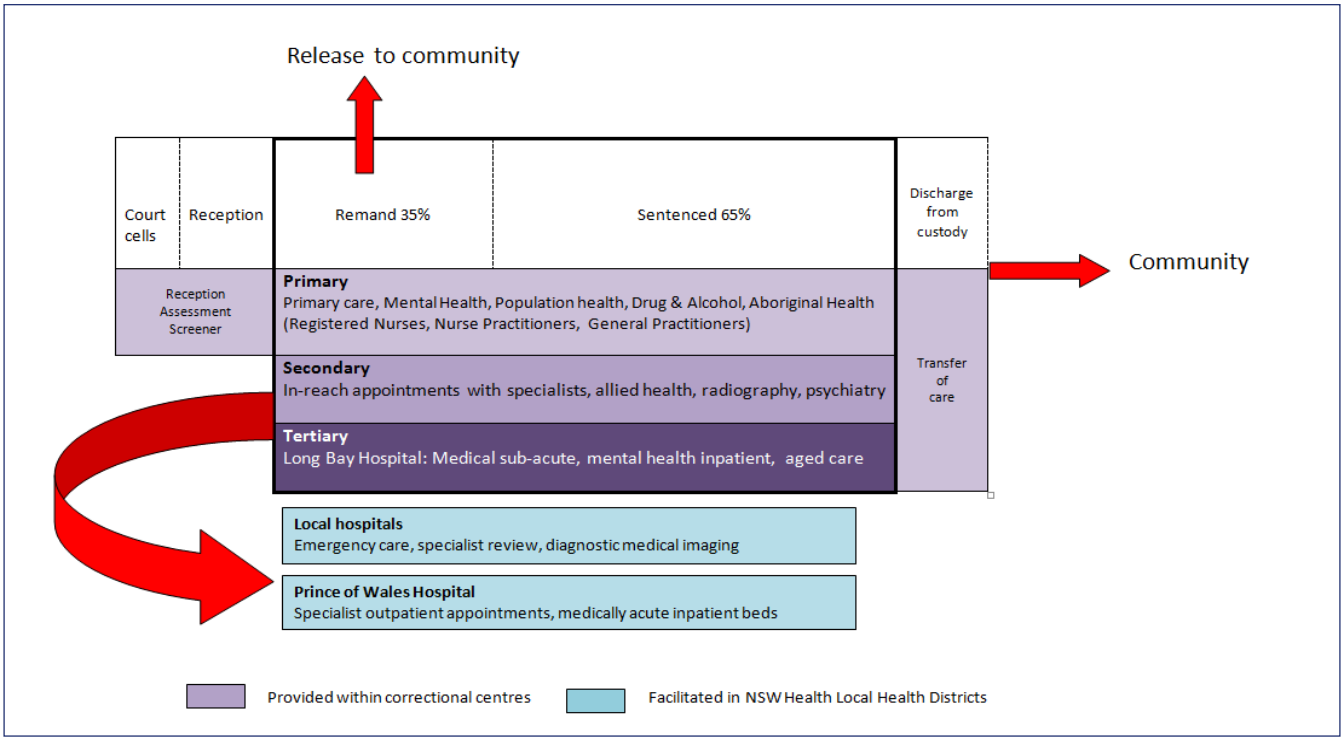
176 Justice Health and Forensic Mental Health Network, 'Access to Local Public Health Services' (Policy 1.252, 16 December 2013) 2.

177 Justice Health and Forensic Mental Health Network, 'Access to Local Public Health Services' (Policy 1.252, 16 December 2013) 3.

178 Corrective Services NSW, Requests for Private Medical Practitioners (Custodial Operations Policy and Procedures, Policy 9.5, 16 December 2017) 4.

The comprehensive offender health model is depicted below:

Figure 1: Model of comprehensive offender health provided in NSW correctional centre



Note: See Corrective Services NSW, Inmate Health Needs (Custodial Operations Policy and Procedures, Policy 6.3, 16 December 2017); Corrective Services NSW, Requests for Private Medical Practitioners (Custodial Operations Policy and Procedures, Policy 9.5, 16 December 2017).

2.4.1 Models of Service Delivery

The 'comprehensive offender health model' is provided in all NSW correctional facilities by a range of service providers with distinct governance and performance monitoring arrangements. The service delivery models in NSW are:

- A 'public-public' model where health services are provided by JH&FMHN inside correctional centres run by CSNSW. This prevails in the majority of NSW correctional centres.
- A 'private-private' model where a single private entity provides custodial and health services under contract with CSNSW. In NSW, this operates at Junee Correctional Centre with GEO, Parklea Correctional Centre with the MTC-Broadspectrum joint venture and sub-contract to St Vincents, Health Network and Clarence Correctional Centre with Serco.[179]
- A 'public-contracted' model where a partnership between public agencies provides custodial and health services under a contract with CSNSW. This emerged for the first time in NSW in May 2017 when a joint public-sector bid between JH&FMHN and CSNSW was announced as the operator of John Morony

179 'Parklea', *NSW Government Department of Communities and Justice* (Web page) <https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/custodial-corrections/table-of-correctional-centres/parklea.aspx>; 'MTC-Broadspectrum Joint Venture Awarded Parklea Correctional Centre Contract', *Broadspectrum: News* (Blog, 15 November 2018) <http://www.broadspectrum.com/news-2018/mtc-broadspectrum-joint-venture-awarded-parklea-correctional-centre-contract> ; 'Broadspectrum, in Partnership with MTC, is to Manage the Parklea Correctional Centre in Australia under a € 57 million per year contract' (Ferrovial, Press Room: Press Releases, 16 November 2018) <https://newsroom.ferrovial.com/en/press_releases/parklea-centre-australia/>.

Correctional Centre following a competitive tender process.[180]

Table 4: Service delivery models of correctional facilities inspected

Correctional facility	Population at time of inspection	Custodial profile*	Custodial service provider	Health service provider
Secure Annex, Prince of Wales Hospital	5	Inmates with acute medical needs	CSNSW	South East Sydney LHD
Tamworth	80	Medium and maximum security remand inmates Minimum security sentenced inmates Significant reception function and high turnover 71% Aboriginal inmates	CSNSW	JH&FMHN
Shortland	279	Maximum security remand inmates High turnover 35% Aboriginal inmates	CSNSW	JH&FMHN
Cessnock	531	Maximum security remand and minimum security sentenced inmates Small number of remand and sentenced female inmates 38% Aboriginal inmates	CSNSW	JH&FMHN
Junee	820	Majority medium security sentenced inmates Small proportion of medium remand and minimum sentenced inmates 35% Aboriginal inmates	GEO	GEO
John Morony	430	Medium security remand inmates 18% Aboriginal inmates	ManageCo (partnership between CSNSW and JH&FMHN)	ManageCo (partnership between CSNSW and JH&FMHN)

*Numbers of Aboriginal inmates based on *CSNSW Aboriginal Offenders Report* 1 August 2018

180 'CSNSW Named as Preferred Bidder for John Morony Correctional Centre', *NSW Government Department of Communities and Justice* (Media Release, 25 May 2017) <https://www.justice.nsw.gov.au/Pages/media-news/media-releases/2017/CSNSW-named-as-preferred-bidder-for-John-Morony-Correctional-Centre.aspx>.

2.4.2 The 'public-public' model

This model involves health and custodial services each provided by separate public entities; that is, health services and clinical governance by JH&FMHN and custodial services by CSNSW. This prevails in the vast majority of NSW correctional centres. The model is unique within Australia as a model of prison health service delivery.

The *NSW Department of Justice and Corrective Services Management of Public Correctional Centres Service Specifications* sets out minimum service requirements of CSNSW regarding health service provision in public correctional centres. The document requires that 'operational cooperation and support is provided to ensure that healthcare facilities and services are provided for inmates in consultation with Justice Health and Forensic Mental Health Network (JH&FMHN) policies and procedures'.[181]

Further, CSNSW must:

1. Ensure written and verbal information about healthcare services is provided to inmates in a form that is accessible to them and appropriate to the inmate's abilities (including taking into account any sensory and cognitive disabilities and in a language that the inmate can understand).
2. Provide inmates with information on and ensure access to health services to address any physical and/ or mental health issues.
3. Ensure systems are in place to prevent the theft or misuse of medical implements and medications.
4. Ensure procedures are in place for infection control.
5. Ensure procedures are in place to manage medical emergencies.
6. Ensure protocols are in place to meet inmate requests and appointments for health services.
7. Ensure security measures are implemented for the dispensing of medication and opioid pharmacotherapies.
8. Provide custodial supervision of the correctional centre clinic or health centre to ensure the safety of health staff and inmates.
9. Ensure procedures are in place for the transfer and escort of custodial patients to public hospitals for emergency in-patient and out-patient services.
10. Ensure all medical records accompany the inmate on transfer from one correctional centre to another Correctional Centre.
11. Ensure inmates in restrictive custodial environments have access to and receive appropriate health services, including those accommodated in close supervision, segregated or protective custody and management beds.[182]
12. Ensure protocols are implemented to ensure health services staff are notified of an inmate's impending release from a correctional centre.

Management support agreements developed by individual correctional centres set out respective responsibilities of Governors and Nurse Unit Managers in achieving health service delivery.

181 Department of Justice: Corrective Services (NSW), *Corrective Services Management of Public Correctional Centres Service Specifications* (no date) 57-8.

182 *Crimes (Administration of Sentences) Regulation* clause 289.

2.4.3 The 'private-private' model

This model involves custodial and health services provided by a single private company or subcontracted health service, under a contract with CSNSW.[183] Junee Correctional Centre is a private-private model, with GEO providing both the custodial and the health service at Junee CC.

The Management Agreement for Junee sets out KPIs relating to custodial operations. GEO is obliged to keep all custodial policies consistent with the CSNSW *Custodial Operations Policies and Procedures* (COPP) and government policy.[184] Under section 242 of the *Crimes (Administration of Sentences) Act 1999* a monitor is employed by the Commissioner of CSNSW to assess and review the centre. The monitor is to have free and unfettered access to the centre, records, and inmates. KPIs are monitored and subject to performance linked fees if achieved or fee reduction if targets are not met.[185]

The Management Agreement for Junee Correctional Centre states:

> 15 (a) The Operator shall, at its own cost:
>
> (i) Provide and co-ordinate the Health Service
>
> (ii) Be responsible for maintaining any Authority in respect of the Health Services as is required by any legislative requirement and any accreditation of the Health Service which is consistent with best practice;
>
> (iii) Shall maintain such records in relation to the health services as is required by any legislative requirement and in accordance with prudent medical and/or dental practice[186]

A new Management Agreement came into force at Junee CC since the time of the inspection. Under this Agreement, GEO is required to have its own health service policies and procedures, although they are required to align with JH&FMHN policies. The new Management Agreement also requires Junee to be accredited under the Royal Australian College of General Practitioners (RACGP) Standards for Health Services in Australian Prisoners, instead of the Australian Council on Healthcare Services (ACHS) Standards.[187]

The health services provided in Junee CC are managed by a Health Service Manager (equivalent to a NUM) who reports to the general manager of the correctional centre.[188] GEO meets quarterly with JH&FMHN and CSNSW regarding any issues in the health centre at Junee CC. The Junee CC health services manager is required to phone in to a bi-monthly quality and safety meeting chaired by the JH&FMHN Director of Nursing and Midwifery Services. The CEO of JH&FMHN has free and unfettered access to the centre, medical records, and inmates, under the *Crimes (Administration of Sentences) Act 1999*.[189]

Under the new Management Agreement, clinical support is provided to Junee via GEO's internal processes and clinical governance structures including: GEO Director, Health Services; GEO Clinical Advisor; GEO Medical Advisor; Health Service Quality and Safety Committee; National Medicines Safety and Advisory

183 This model operates at Junee, Parklea and Clarence correctional centres.

184 Commissioner of Corrective Services (NSW) and The GEO Group Australia Pty Limited, *Management Agreement for Junee Correctional Centre* (30 April 2009) cls 5.1b(vii)-(viii); "The Commissioner of CSNSW must advise GEO of changes to CSNSW policy in writing as required by Commissioner of Corrective Services (NSW) and The GEO Group Australia Pty Limited, *Management Agreement for Junee Correctional Centre* (30 April 2009) cl 6.6.

185 See Commissioner of Corrective Services (NSW) and The GEO Group Australia Pty Limited, *Management Agreement for Junee Correctional Centre* (30 April 2009) schedule 8: Key Performance Indicators and Performance Linked Fee.

186 Commissioner of Corrective Services (NSW) and The GEO Group Australia Pty Limited, *Management Agreement for Junee Correctional Centre* (30 April 2009) 22.

187 Information provided by GEO 21 January 2021.

188 Interviews with JH&FMHN staff and GEO staff 2018.

189 *Crimes (Administration of Sentences) Act 1999* s 244(1).

Committee.[190] A Medical and Dental Appointments Advisory Committee vets all psychologists, doctors and psychiatrists working in GEO health centres.

Further delivery models are emerging. On 31 March 2019, Management and Training Corporation-Broad Spectrum (MTC-BRS) commenced its operation of Parklea CC. It subcontracts to St Vincent's Health Network to deliver medical and health care services to inmates at Parklea CC. A combination of nurses and GPs are used to provide a 24 hour on-site health service.

2.4.4 The 'public contracted' model

This model operates in NSW at John Morony Correctional Centre, Windsor. Management of the centre occurs under an operating agreement between CSNSW and 'ManageCo', a collaboration between JH&FMHN and CSNSW. ManageCo was created to enable a public bid for the tender to operate John Morony. The operating agreement sets out a range of health delivery KPIs, including:-

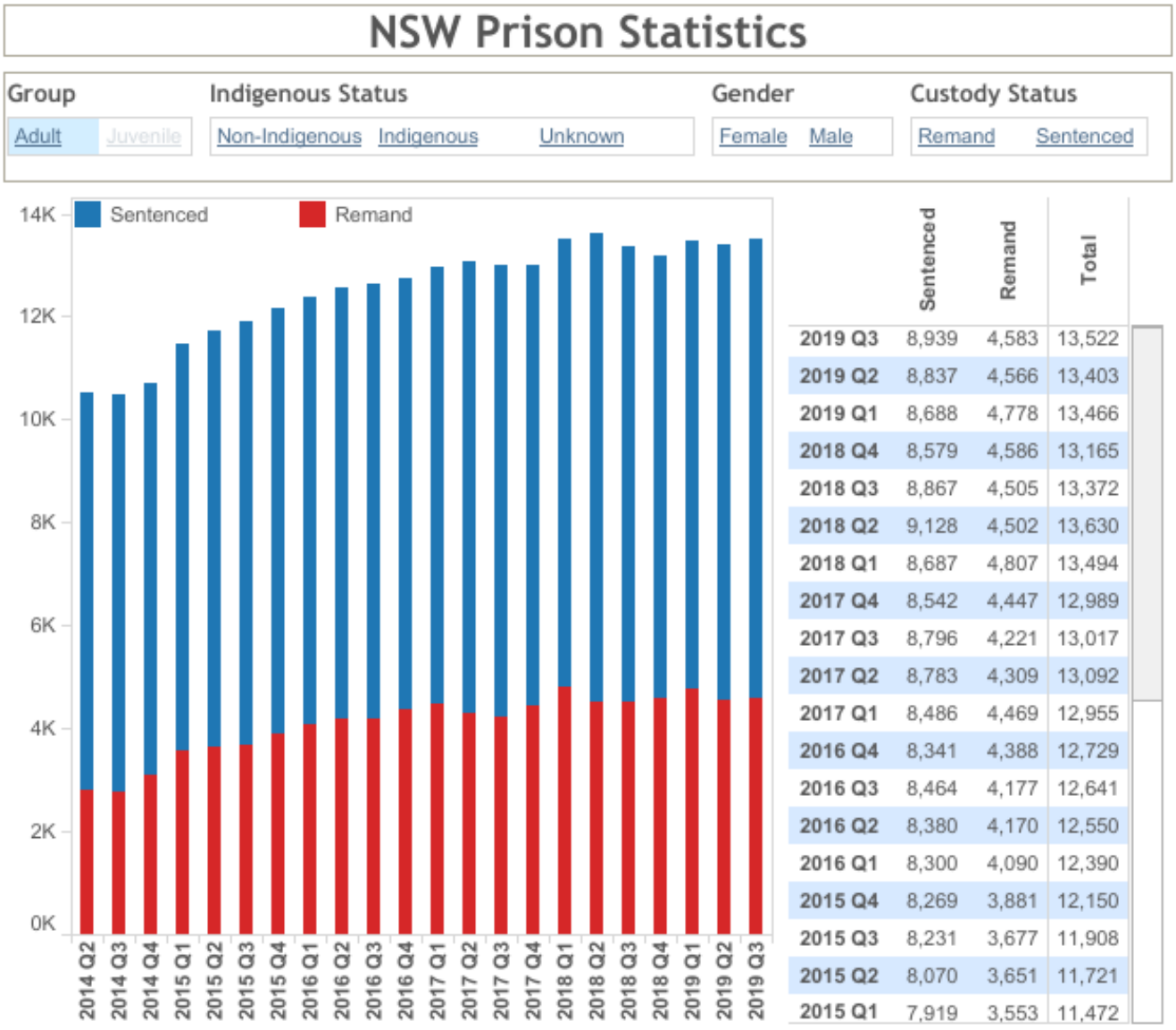
- Numbers of patients with chronic health care plans
- Timely provision of health service to high priority patients
- Numbers of health discharge plans
- Early detection programs and immunisation services
- Health-related incident reporting
- Health screening

190 Information provided by GEO 21 January 2021.

2.5 Demand for health services

Since 2015, prisoner numbers in NSW have continued to increase, as shown at Figure 2 below.

Figure 2: NSW Prison Statistics 2014 to 2019[191]



	Sentenced	Remand	Total
2019 Q3	8,939	4,583	13,522
2019 Q2	8,837	4,566	13,403
2019 Q1	8,688	4,778	13,466
2018 Q4	8,579	4,586	13,165
2018 Q3	8,867	4,505	13,372
2018 Q2	9,128	4,502	13,630
2018 Q1	8,687	4,807	13,494
2017 Q4	8,542	4,447	12,989
2017 Q3	8,796	4,221	13,017
2017 Q2	8,783	4,309	13,092
2017 Q1	8,486	4,469	12,955
2016 Q4	8,341	4,388	12,729
2016 Q3	8,464	4,177	12,641
2016 Q2	8,380	4,170	12,550
2016 Q1	8,300	4,090	12,390
2015 Q4	8,269	3,881	12,150
2015 Q3	8,231	3,677	11,908
2015 Q2	8,070	3,651	11,721
2015 Q1	7,919	3,553	11,472

While the NSW inmate population peaked in 2018 at 13,630, this does not reflect the total number of inmates moving through the system each year. In 2018, 19,129 individuals were received to custody, and 16,351 discharged.[192]

191 Source: 'Custody Statistics: Custody Reports', *NSW Bureau of Crime Statistics and Research* (Web Page) https://www.bocsar.nsw.gov.au/Pages/bocsar_custody_stats/bocsar_custody_stats.aspx.

192 Information from CSNSW provided to ICS, 8 April 2019.

As shown in Table 5 below many inmates spend relatively short periods of time in custody before returning to the community.

Table 5: Average Length of Stay for Adult Inmates Discharged from Custody per Quarter in late 2019

JUN19		Remand Custody Only		Sentenced Custody Only		Remanded to Sentenced Custody	
		JUN19	SEP19	JUN19	SEP19	JUN19	SEP19
Total Male	Avg Days Number	59.1 1646	56.1 1634	231.8 793	272.4 855	421.8 1814	443.4 1800
Total Female	Avg Days Number	47.4 351	42.5 352	130.5 155	136.0 128	268.4 190	350.7 196
Indigenous Male	Avg Days Number	59.9 400	61.0 439	230.1 238	249.8 266	320.7 583	297.2 511
Indigenous Female	Avg Days Number	58.1 138	39.8 135	89.4 58	102.3 54	247.5 84	204.4 80
Total	Avg Days Number	57.0 1997	53.7 1986	215.2 948	254.6 983	407.3 2004	434.3 1996

Note: Length of Stay for Remand to Sentenced Custody is from the date of reception on remand to date of discharge after serving sentence.

Source: NSW Bureau of Crime Statistics and Research, *New South Wales Custody Statistics: Quarterly Update September 2019* (Report, September 2019) 35, Figure 2.3.4.

The increase in inmate population has resulted in a decrease in the ratio of FTE nursing staff to inmates in correctional centres.[193] The rate of FTE nursing staff to inmates decreased from 3.2 in 2013 to 2.6 in 2017.

Overall population increase, combined with high numbers moving through the system each year even for short periods, has placed extra demand on prison health services in NSW. This is because each person entering the correctional environment, even for the shortest period of time, needs to be fully assessed from a health, welfare and safety perspective.

From a health perspective, this is to ensure high risk health and mental health issues are identifed as they enter, previously prescribed medication needs to be confirmed, ordered, administered (within a secure environment) and both current and emerging acute and chronic health issues need to be identified, assessed and managed.

This is different from what a health service in the community would be expected to do due to the custodial environment and patient profile. This is the predominate workload of the health service and health professionals working within the custodial environment.

Although increased demand for health services is not unique to NSW, what is unique to the NSW correctional system within the Australian context is the number of correctional centres, many of which are

193 The rate of FTE nursing staff to inmates decreased from 3.2 in 2013 to 2.6 in 2017.This is the rate per 100 inmates; see Audit Office of New South Wales, *Report on Justice 2017* (New South Wales Auditor-General's Report, 28 November 2017) 34.

located in regional areas.[194] Crowding[195], court appearances, program availability, and classification and placement decisions result in a significant number of transfers between correctional centres each year. This places a demand on health resources because every time an inmate is transferred their health records must be transferred, and they must be assessed by health services upon reception at their new centre.[196] In 2018 there were 54342 transfers between correctional centres. The frequency of movement through the NSW system each year is shown in Table 6 below:[197]

Table 6: CSNSW custodial movements, 2018

Month (2018)	New Receptions	To Court	From Court	Transfer	Centre Discharge	Court Discharge	Total
January	1420	5626	5399	3766	1169	187	17380
February	1517	7424	7166	5013	1206	224	22326
March	1818	8030	7741	5418	1267	270	24274
April	1572	7278	6987	4286	1277	231	21400
May	1669	8766	8474	5103	1359	252	25371
June	1538	7953	7708	4965	1366	220	23530
July	1545	8022	7715	4584	1453	250	23319
August	1603	8541	8220	4712	1389	289	24465
September	1540	6147	5902	4192	1413	222	19194
October	1537	2959	2663	4139	1539	238	12837
November	1606	2862	2585	4303	1454	254	12810
December	1764	1594	1347	3861	1459	224	10025
Total	19129	75202	71907	54342	16351	2861	236931

* The totals do not include court discharges

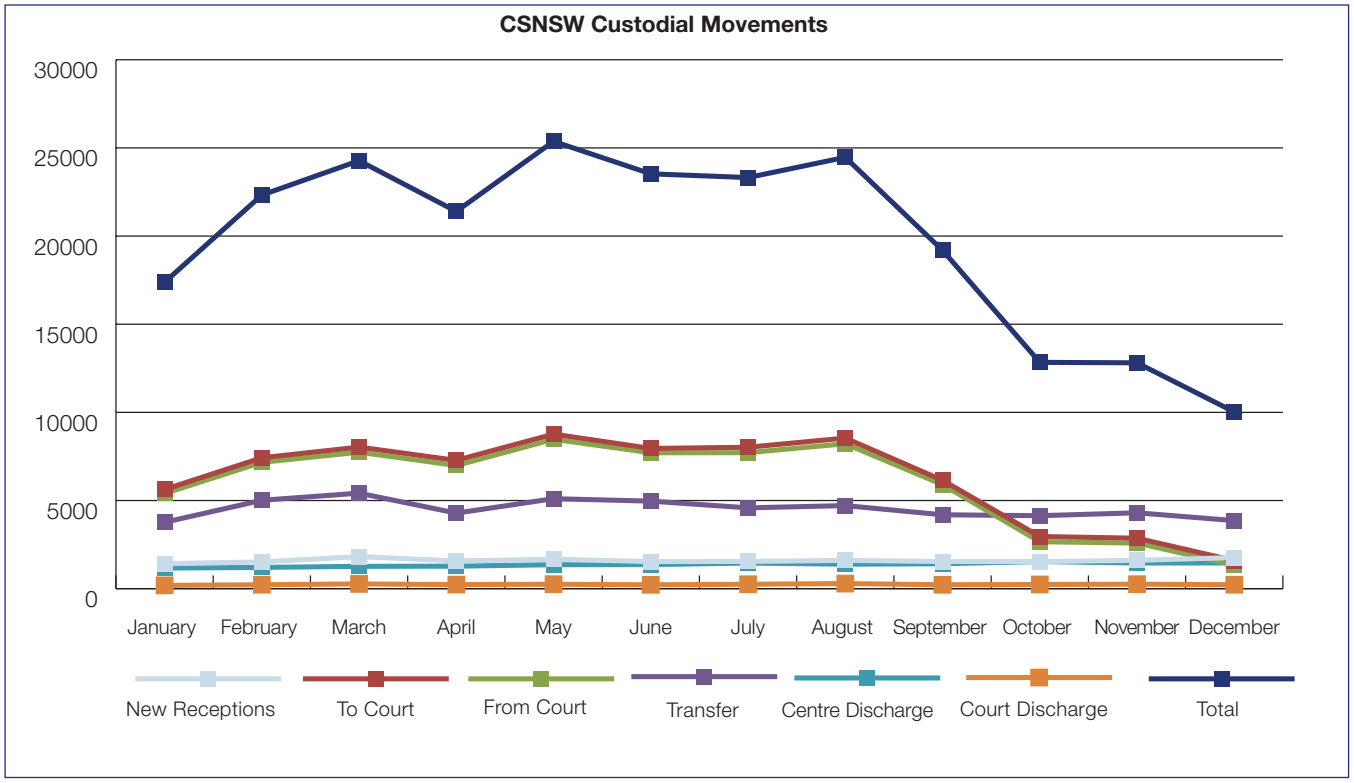
194 There are a total of 53 correctional custodial facilities in NSW as at 30 June 2019, see Report on Government Services, *Corrective Services* (2020) Table 8A.3. ;See 'Correctional Centres in NSW', *Department of Communities and Justice: Corrective Services;* <https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/custodial-corrections/table-of-correctional-centres/correctional-centres.aspx>

195 Inspector of Custodial Services (NSW), *Women on Remand*, February 2020, p.11; The Prison Bed Capacity Adjustment Program will remove around 1,800 short-term double-up and triple-up beds across the system to reduce overcrowding in prisons. . Corrective Services NSW, Better Prisons, 2020, https://correctiveservices.dcj.nsw.gov.au/csnsw-home/correctional-centres/better-prisons.html#:~:text=in%20Berkshire%20Park.- Prison%20Bed%20Capacity%20Adjustment,and%20upgraded%20prisons%2C%20become%20operational

196 *Crimes (Administration of Sentences) Regulation 2014* clause 284.

197 Information from CSNSW provided to ICS, 8 April 2019.

Figure 3: CSNSW Custodial Movements During 2018



In 2018 there were 19,129 individual receptions, 16,315 individual discharges, 54,342 transfers between centres and 71,907 inmates returning from a court attendance (see Table 6).[198]

Each reception, transfer[199] and discharge requires health staff to provide assessments, identify high-risk patients, maintain continuity of care, facilitate medication, and conduct health assessments. This involves significant record keeping as well as patient engagement, and must occur in addition to the provision of primary care and medication to the inmates accommodated in centres. Considering the prevalence of mental health, substance use and chronic health issues among inmates, the sheer numbers moving through the system each year places significant pressure upon the provision of prison health services already constrained by workforce and operational factors.

Although the arguments for extending the use of AVL for court appearances extend well beyond reducing the burden on health resources, the increased use of AVL for court appearances resulting in a reduction in operational transfers between centres would reduce the burden on health staff to conduct reception and discharge assessments.[200] In turn this would increase the amount of time available to deliver primary health services.

The demands placed on prison health services have been previously identified in public reports. The 2015 ICS report *Full House* noted the impact of rising prisoner numbers on the adequacy of health staffing, infrastructure and access hours.[201] Also published in 2015, the ICS report, *Old and Inside* identified the challenge of meeting the complex healthcare needs of an increasing ageing population in an environment

198 Source: CSNSW, provided 8 April 2018.

199 *Crimes (Administration of Sentences) Regulation 2014* clause 284.

200 More than 81,000 court matters have been facilitated by AVL in the period from 1 July 2019 to 30 June 2020. This is a 9.3% increase on the 2018/19 financial year. Benefits achieved during the COVID-19 response has resulted in additional funding from the Digital Restart Fund to improve the quality and availability of technology, Information provided by CSNSW, 4 February 2021.

201 See Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population in NSW' (Report, April 2015) 49-59.

already strained of resources.[202] A 2018 report by the NSW Legislative Council found JH&FMHN to be under-resourced to meet demand, particularly in relation to mental health need.[203]

2.6 Complaints about health services

The challenges in meeting the demand for health services within the NSW correctional system is reflected in the number of complaints about health services.

There are a number of complaint mechanisms available to inmates in relation to health services; speaking to the Nurse Unit Manager at the correctional centre[204]; contacting the Justice Health Patient Inquiry Line[205]; speaking to an Official Visitor; contacting the NSW Ombudsman; and contacting the Health Care Complaints Commission. The Justice Health Patient Inquiry Line, Official Visitor Program, NSW Ombudsman and Health Care Complaints Commission are all able to be accessed via a free call from communal phones in correctional centres.

The table below provides the number of calls to the JH&FMHN Inquiry line in 2018:[206]

Table 7: JH&FMHN Patient Health Inquiry Line calls

JH&FMHN Patient Health Inquiry Line 2018	
Total number of calls received	8,124
Total number of calls answered	6,108
Total number of calls missed	2016
Percentage of calls answered	75%

The JH&FMHN *Patient (Consumer) Complaints Handling Policy* outlines the obligations of the responsibilities of staff at different levels in handling complaints. Staff at all levels must accept complaints and know what action to take to respond and resolve the complaint. JH&FMHN must ensure strategic oversight of complaints, and report trends to its clinical governance committee. JH&FMHN are subject to NSW Ministry of Health benchmarks that 100% of complaints are to be acknowledged within five days of receipt, and that 80% of complaints are to be responded to within 35 calendar days.[207] JH&FMHN met both targets in 2016-2017. In 2016-2017, the two highest reported types of complaints were about access to health services and treatment.

Inmates may also contact the Health Care Complaints Commission (HCCC) via phone.[208] Calls from correctional centres generally constitute a high proportion of all calls received by the HCCC, as shown at Figure 4 below:[209]

202 Inspector of Custodial Services (NSW), 'Old and Inside: Managing Aged Offenders in Custody' (Report, September 2015) 50.

203 Legislative Council Portfolio Committee No. 4: Legal Affairs, Parliament of NSW, *Parklea Correctional Centre and Other Operational Issues* (Report 38, December 2018) 109.

204 JH&FMHN, *Patient Health Service Information* (Brochure, no date) 22.

205 The Justice health Patient Inquiry Line was established in January 2018 JH&FMHN response to ICS data request 2, item 74, 8 February 2019.

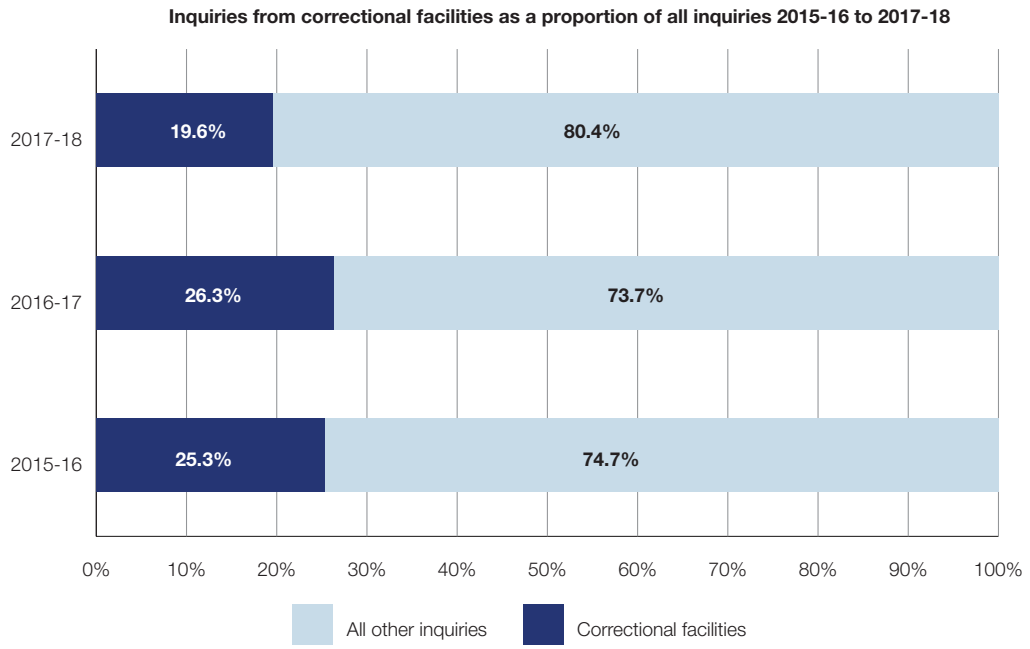
206 Information provided by JH&FMHN, 18 February 2019.

207 Justice Health and Forensic Mental Health Network, *Year in Review 2016-2017* (Department of Health (NSW), Report, December 2017) 71.

208 The Health Care Complaints Commission is an independent body established under the *Health Care Complaints Act 1993* for the purposes of receiving and assessing complaints regarding health services and health service providers in NSW.

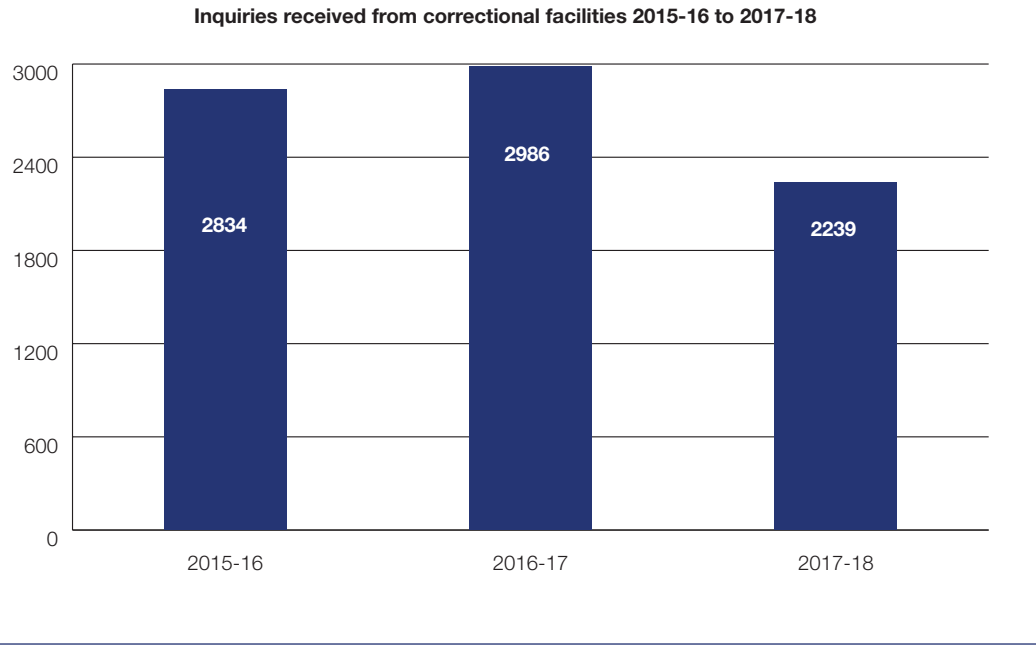
209 Data provided by Health Care Complaints Commission (8 February 2019).

Figure 4: Inquiries from correctional facilities as a proportion of all inquiries to the HCCC in the period 2015-16 to 2017-18



Phone contacts to the HCCC from correctional centres have decreased since the introduction of the JH&FMHN Inquiry Line. This is illustrated below at Figure 5:[210]

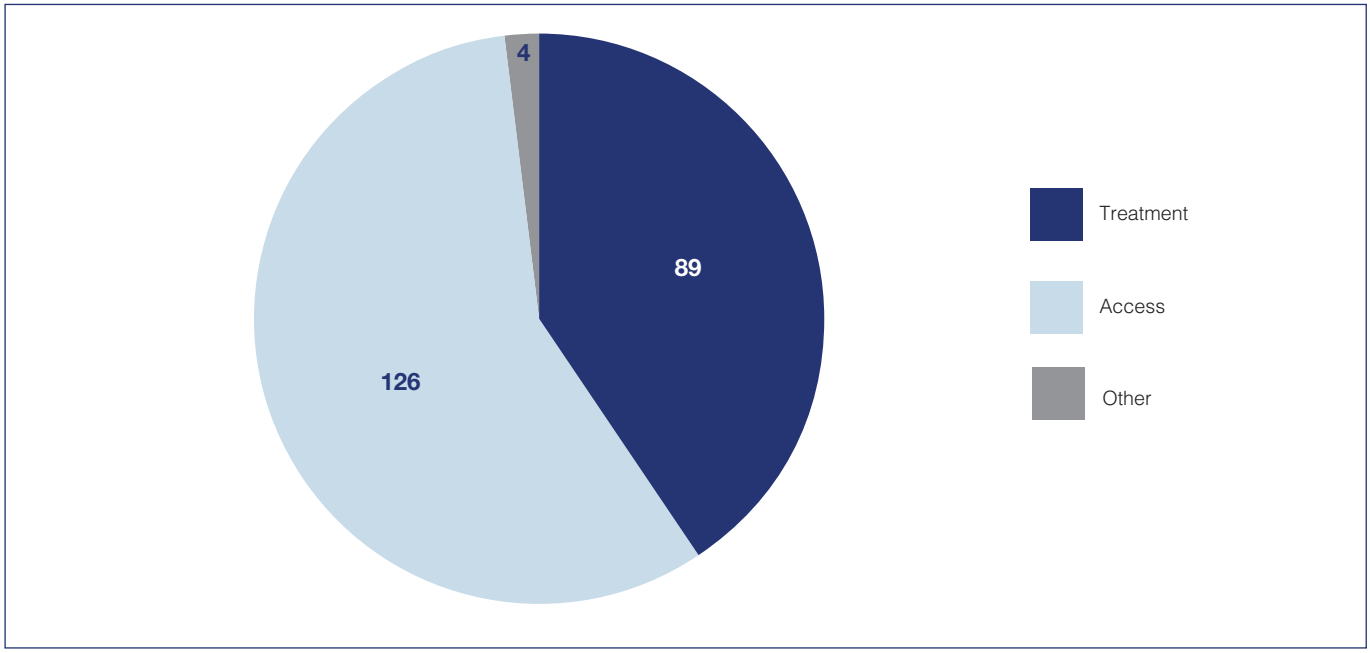
Figure 5: Inquiries from correctional facilities to the HCCC in the period 2015-16 to 2017-18



210 Data provided by Health Care Complaints Commission, February 2019.

The HCCC has advised that enquiries from correctional centres are often repeat callers regarding service access or information about medication.[211] Categories of complaints received by the HCCC are outlined below in Figure 6:[212]

Figure 6: Complaints received by HCCC referred to JH&HMHN for local resolution



The HCCC may refer complaints back to JH&FMHN for local resolution. In 2017-2018, 79.1% of complaints about correctional and detention facilities received by the HCCC were referred for local resolution.[213] Resolution was satisfactory for 184 matters, partial for 19 matters, and not satisfactory/NA for 21 matters.[214]

In 2016-2017, 2017-2018 and 2018-2019, medical issues were the highest category of complaints received from inmates by NSW Official Visitors.[215] This is a rate of 17.9 complaints per 100 inmates for the period 2017-2018,[216] and 15.5 complaints per 100 inmates in 2018-2019.[217] In 2016-2017, medical issues were also the highest area of complaint made to the NSW Ombudsman, and the second-highest category in 2017-2018 and 2018-2019.[218]Depending on the nature of the complaint, the Ombudsman may refer callers to the Justice Health Patient Health Inquiry Line or the HCCC.

Some complaints about treatment will be subject to a Root Cause Analysis (RCA) investigation as deemed appropriate by the CEO of JH&FMHN, following advice from the Director clinical and corporate governance. An RCA is a method used to investigate and analyse a clinical incident to identify the root causes and factors that contributed to the incident and to recommend actions to prevent a similar occurrence. When a complaint is subject to an RCA, it may not be possible to fully respond to the complaint until the RCA investigation is complete.[219]

211 Health Care Complaints Commission, *2017-2018 Annual Report: Protecting Public Health and Safety* (2018) 69.

212 Information provided by JH&FMHN.

213 In 2016-17, this figure was 67.2%. In 2015-16 it was 71.0%. See Health Care Complaints Commission, *Annual Report 2016-17: Protecting Public Health and Safety* (2017) 38.

214 Information provided by JH&FMHN.

215 Inspector of Custodial Services (NSW), *Annual Report 2016-17* (December 2017) 13; Inspector of Custodial Services (NSW), *Annual Report 2017-18* (October 2018) 16; Inspector of Custodial Services (NSW), *Annual Report 2018-19* (October 2019) 14.

216 Inspector of Custodial Services (NSW), *Annual Report 2017-18* (October 2018) 16.

217 Inspector of Custodial Services (NSW), *Annual Report 2018-19* (October 2019) 14.

218 Ombudsman (NSW), *Annual Report 2016-2017* (20 October 2017) 83; Ombudsman (NSW), *Annual Report 2017-2018* (22 October 2018) 82; Ombudsman (NSW), *Annual Report 2018-19* (31 October 2019) 27.

219 Justice Health and Forensic Mental Health Network (NSW), *Consumer Complaints Handling* (Policy 2.015, 10 January 2019) 7.

Inmates at Junee CC have the same level of access to the HCCC, NSW Ombudsman and Official Visitors as public prisons. However, due to the withdrawal of JH&FMHN's Primary Health Enquiry Process (PHEP), Junee has implemented a similar mechanism for inmate patients to voice concerns/ register complaints. This system is managed locally by the Health Services Manager and Clinical Quality Coordinator.[220] GEO also has its own *Health Related Incident and Complaint Reporting Management* policy. Root cause analyses following clinical incidents are performed by the clinical advisor and medical advisor within the clinical governance team.[221]

220 Information provided by GEO 21 January 2021.

221 Information provided by GEO staff October 2019.

Chapter 3. Health services available to inmates

The challenge for prison health services in NSW is to provide all basic health services in a restricted environment to a population with generally poor health and particularly high needs in the areas of mental health and drug and alcohol. This task is made even more complex by the sheer volume of people moving through the system each year. The associated coordination of continuity of care with community health providers required for each individual entering and exiting the system is significant.[222]

An inmate's contact with health services is initiated upon admission into a correctional centre. A Reception Screening Assessment (RSA) must be conducted by a Registered Nurse within 24 hours of admission. Presenting issues will be treated immediately if possible, and referral to a GP or other specialist service may be generated. Non-urgent issues requiring treatment will be referred to a primary health clinic waitlist which is triaged by a NUM. A priority upon admission is seeking a Request for Information (ROI) from the inmate's healthcare provider in the community. This is to ensure continuity of care; for example, the provision of prescription medication.

In order to maintain patient confidentiality, if a health need is identified on reception, a Health Problem Notification Form (HPNF) will be completed. These forms are for health staff to communicate to CSNSW clinical symptoms with which the patient may present, information regarding the inmates' actual or potential risk to self or others, and clinically based recommendations around an inmates' management and placement.[223] This information may be around substance withdrawal, mental health, epilepsy or diabetes. The specifics of a patient's diagnosis and diseases are kept confidential, with information provided to custodial staff for patient safety. HPNFs are also updated as an inmate's clinical status changes.[224]

Once inducted into the correctional environment, inmates with non-urgent health issues generally access health services via a paper-based request form. Request forms are reviewed and triaged by a primary health nurse. In some centres, inmates are able to seek assistance in person.

If an urgent health issue or emergency arises inmates or their cell mate are able to contact custodial officers. If health staff are on site, they will respond. After hours, custodial staff may consult with the after hours Nurse Manager and/or call an ambulance.

3.1 Primary care

Primary care is the health care a patient receives upon first contact with the health care system.[225] In the community most people receive primary care through GPs. In the majority of NSW correctional centres JHFMHN provides nursing coverage and limited GP hours. Primary health is provided in a tiered system, led by Registered Nurses (RNs) who provide care within their individual scope of practice, including any advanced or extended roles. Higher levels of need or matters outside nurses' scope of practice are referred to a GP, Nurse Practitioner (NP) or Transitional Nurse Practitioner (TNP). Responsibilities of health staff are outlined below:

222 There were over 18000 admitted and 18000 discharged in the 2017-2018 period, see Justice Health and Forensic Mental Health Network, *Our Network 2018* (NSW Department of Health, December 2018) 33.

223 Corrective Services NSW, *JH&FMHN notifications* (Custodial Operations Policy and Procedures, Policy 6.1, 16 December 2017) 4.

224 Justice Health and Forensic Mental Health Network, 'Health Problem Notification Form (Adults)' (NSW Department of Health, Policy 1.231, 20 June 2016) 5.

225 Justice Health Statewide Service and NSW Health, Justice Health: Health Services Brochure (November 2009) 9.

Table 8: Roles and Responsibilities of health centre staff

Registered Nurses	Nurse Practitioner	GP
Assessment and treatment for common conditions; prevention, early detection and ongoing management of chronic conditions; provision of care within their individual scope of practice, including any advanced or extended roles and emergency interventions for acute conditions.[226]	While scope of practice is individual to each NP, all are authorised to initiate diagnostic investigations, prescribe medications and make referrals.[227]	As in the community, GPs prescribe medication, undertake comprehensive health risk assessments, and make referrals to secondary levels of care, such as specialists.

The Chief Executive of JH&FMHN may appoint one or more registered medical practitioners (GP) for a correctional centre.[228] GP, NP and TNP hours are variously allocated to centres based on anticipated demand and the prisoner health profile.

At the time of drafting JH&FMHN custodial health comprised the following NP or TNP allocation to be utilised across the system:

Table 9: Allocated NP or TNP FTE. Source: JH&FMHN Data received January 2019.

Clinical stream	JH&FMHN NP or TNP FTE allocation
Population Health	2 NP
Primary Care	2 NP 1 TNP
Women's Health	1 NP
Drug and Alcohol Services	3 NPs
Custodial Mental Health	1 NP
Women's Custodial Mental Health	1 NP

The scope of practice, clinical area of focus and training requirements for nurse practitioners are specific and therefore the available pool of nurse practitioners is limited.

In JH&FMHN centres, primary health clinics are facilitated on particular days by an RN. At Junee Correctional centre, a General Practitioner sees inmates in a daily primary health clinic with a priority list triaged by the Health Services Manager.

A JH&FMHN Remote Offsite After Hours Medical Service (ROAMS) operates 24-hours per day, linking health centres with drug and alcohol, mental health and population health specialist nurses as well as senior operational managers. These services may be utilised by primary health nurses seeking specialist

226 Justice Health Statewide Service and NSW Health, Justice Health: Health Services Brochure (November 2009) 9.

227 A Nurse Practitioner is a nurse who has met the requirements of the Nursing and Midwifery Board of Australia) and may initiate diagnostic investigations, prescribe medications and make referrals. 'NPs work at an advanced practice level that demands expert clinical knowledge, advanced specialised education, complex decision making skills, clinical reasoning and diagnostic skills and ability to initiate and evaluate therapeutic management plan'; see 'Nurse Practitioners in NSW', *NSW Government: Health* (Web page) <https://www.health.nsw.gov.au/nursing/practice/Pages/nurse-practitoner.aspx>.

228 Section 236C of the *Crimes (Administration of Sentences) Act 1999*.

advice, and by CSNSW staff in the absence of JH&FMHN staff.[229] Primary care can also be provided via telehealth video link to a remotely located medical officer. Both CSNSW and GEO have 24-hour access to the JH&FMHN after hours nurse manager telephone service. At Junee CC, the GPs who attend the centre during the day are also on call for after-hours advice. Since the inspection, a GP led model of service delivery has also been implemented at Parklea Correctional Centre.[230]

3.1.1 Shared care model

A 'shared care model' operates in all JH&FMHN-run health centres.[231] The model involves primary care nurses providing initial services across mental health, public health and drug and alcohol streams.[232] Primary health nurses may then generate referrals to specialist staff at centrally located centres, with support provided via telehealth, site visits or telephone.

JH&FMHN reports that the model reduces time required for medication administration and increases time for direct care.[233] Health staff interviewed by the inspection team felt the shared model of care reduced waiting times and bulk referrals to specialty streams.[234]

Roll out of the model was supported by three days of training for all registered and enrolled nurses working in JH&FMHN health centres. The training covers primary care, mental health, drug and alcohol and infectious diseases to ensure network nursing staff had skills to provide adequate care and knew when to utilise speciality services.[235] It is evident that JH&FMHN are committed to training their staff. Nevertheless the inspection team was made aware of a case where primary health nurses had been allocated specialty portfolios under the shared model of care, but a skill gap remained.[236] The shared model of care will need to be supported by continued adequate training, supervision and clinical support.[237] The standard of health care provided to inmates should be comparable to that available in the community.[238] It may be timely to review the custodial health delivery model to ensure the nursing dominated model of primary care is equivalent to a community standard of care, and that the nursing scope of practice and skill level is appropriate to respond to the health profile of the custodial environment.

Recommendation 1: A review of the custodial health delivery model occurs to ensure health care provided to inmates is comparable to that available in the community.

Recommendation 2: JH&FMHN ensure the shared model of care is supported by ongoing adequate training, supervision and credentialing for all primary care nurses, with avenues for identifying and addressing skill gaps.

229 A Clinical Assessment Software (CAS) form within JHeHs should be completed by the nurse before ROAMS in contacted. ROAMS services Primary Care, Mental Health, or Drug and Alcohol. Interview with staff 2018.

230 On 31 March 2019, Management Training Corporation-Broad Spectrum (MTC-BRS) commenced its operation of Parklea CC. It subcontracts the St Vincent's Health Network to deliver medical and health care services to inmates at Parklea CC.

231 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 56.

232 Information provided by JH&FMHN.

233 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 6.

234 Interviews with staff, April 2018.

235 Information provided by JH&FMHN.

236 Interviews with Staff, April 2018.

237 JH&FMHN is working in collaboration with a NSW university to provide a specific qualification up to masters level in Custodial Nursing. Information provided by JH&FMHN 21 February 2021.

238 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), GA Res 70/175, UN Doc A/RES/ 54/254 (8 January 2016, adopted 17 December 2015) rule 24(1)'.

3.2 Mental health

Mental health is an important consideration for prison health services. The forensic mental health and custodial mental health systems are two distinct but interrelated service areas in NSW. Forensic patients have been found to be unfit to be tried for an offence, or been found not guilty by reason of mental illness, and ordered to be detained.[239] Forensic patients may be held at The Forensic Hospital, Malabar, or Long Bay Hospital, a gazetted correctional centre and declared mental health facility. JH&FMHN provides health and psychiatric services at both facilities.

Custodial mental health relates to the mental health services provided to people incarcerated in NSW prisons. It comprises graduated levels of care and includes specialised facilities at the Mental Health Screening Unit, Metropolitan Remand and Reception Centre, Silverwater (MRRC) and Long Bay Hospital. Custodial mental health is the focus of this report however the impact of the forensic mental health system on the custodial health system will be discussed.

3.2.1 Servicing the general population

The need for custodial mental health services may be identified upon reception to prison. New receptions to the MRRC and Silverwater Women's CC undergo a Prison Mental Health Screener (PMHS). This is a validated tool developed by JH&FMHN specifically for identifying high-risk patients in a custodial setting who require referrals on to custodial mental health teams (CMH) comprising mental health nurses, nurse practitioners and psychiatrists. Use of the PMHS at the MRRC and Silverwater Women's CC found that 18.5% of male and 37.2% of female receptions met the criteria for referral to mental health teams.[240] This demand for mental health support upon reception should be considered when allocating staffing at remand and reception centres. Consideration also needs to be given to Aboriginal women and their specific needs. Mental health need may also be identified by an inmate making a request to see a primary health nurse, who may then generate a referral on to custodial mental health (CMH). If health staff believe that the mental state of an inmate requires special observation, this must be reported to a prescribed CSNSW officer as soon as practicable.[241]

Mental health nurses are employed at larger correctional centres where the need is greatest, and may be accessed via telehealth at other centres. Mental health nurses have a broad scope of practice, including clinical and risk assessment, medication management and therapeutic interventions. Mental health nurses provided 38,680 services to inmates in JH&FMHN correctional centres in the period 2017-2018. [242] Mental health nurse practitioners may also screen and treat high-prevalence disorders such as depression, anxiety and some chronic schizophrenia. Psychiatrists service 18 of the 33 JH&FMHN correctional centres on allocated days, seeing patients from a list triaged by primary health nurses or mental health nurses the previous evening.[243] Junee CC delivers psychiatry services using telehealth.[244]

Mental health advice and support is also available to inmates and their families via a 24 hour mental health helpline.[245] The line is staffed by trained mental health nurses who may make referrals to mental health

239 *Mental Health Review Tribunal*, 'Forensic Procedures' (Web Page) <https://www.mhrt.nsw.gov.au/forensic-patients/forensic-procedures.html>.

240 Justice Health and Forensic Mental Health Network, Prison Mental Health Screener study (Unpublished, 2018); Information from Justice Health and Forensic Mental Health Network, June 2019.

241 Crimes (Administration of sentences) Regulation 2014 clause 286.

242 These services are called non-admitted patient occasions of service. Information provided by JH&FMHN.

243 Interviews with Staff December 2018.

244 Information provided by GEO 21 January 2021.

245 *NSW Government Health: Justice Health and Forensic Mental Health Network*, '24 Hour Mental Health Helpline' (Web Page) <https://www.justicehealth.nsw.gov.au/patient-support/24-hours-mental-health-helpline>.

services within JH&FMHN.[246] GEO sub-contract JH&FMHN (under a MOU) to provide this service pursuant to the new Management Agreement requirements.[247]

Psychologists in NSW prisons are employed by CSNSW, not JH&FMHN. Mental health interventions comprise over 50% of services provided by psychologists. They offer a range of services including crisis support, short-term behavioural interventions for acute and chronic mental health interventions, coping strategies for stress and groups to address mental health issues. Psychologists use both cognitive behaviour therapeutic and dialect behavioural interventions to address mental health issues in custody and this work compliments the interventions from JH&FMHN. Psychologists are also responsible for delivering programs related to offending; assessing inmates' risk and criminogenic needs, and preparing psychological reports for courts, parole authorities or the Mental Health Review Tribunal.[248]

Although, due to limited resources, staff are required to prioritise immediate risk to self and others and areas related to offending behaviour, centre psychologists felt competing demands between clinical therapeutic aspects on the one hand, and criminogenic-focused reporting, assessment and program delivery on the other.[249]

3.2.2 Inmates at risk of self-harm

Risk of self-harm may be identified upon reception screening; self-identified by an inmate presenting to the health centre, or identified by a custodial officer as a result of observing inmate behaviour. CSNSW staff must complete an e-learning training module called *Awareness of Managing At-Risk Offenders.* [250] Notifications of risk must be recorded in the Offender Integrated Management System by CSNSW staff.

As soon as practicable after forming a decision that an inmate is a risk to themselves or others, authorised JH&FMHN staff must advise a prescribed CSNSW officer.[251] Managing inmates at risk of self-harm or suicide is the shared responsibility of custodial and health staff. [252] Assessment, review and management of inmates at risk is the responsibility of a Risk Intervention Team (RIT) in CSNSW centres or the High Risk Assessment Team (HRAT) in the case of GEO-run Junee CC. The CSNSW RIT is coordinated by a senior correctional officer who must have completed a two-day training course on *Managing At-Risk Offenders* at the Brush Farm Corrective Services Academy. The RIT must also include a JH&FMHN staff member and a CSNSW Offender Services and Programs staff member when available or another CSNSW staff member. Initial assessment and ongoing review of the inmate is achieved by the RIT interviewing the at-risk inmate together.[253] Matters for consideration by the RIT are cell placement options, risk of harm to or from others, assessment cell apparel, restraints, observations, diversionary activities, referrals to other services within the correctional centre, and the next review date. The Governor of the centre must adjudicate when RIT members cannot agree on a course of action for managing the inmate.[254]

Management and placement of an inmate at risk will be detailed in an individualised Immediate Support Plan

246 *NSW Government Health: Justice Health and Forensic Mental Health Network*, '24 Hour Mental Health Helpline' (Web Page) <https://www.justicehealth.nsw.gov.au/patient-support/24-hours-mental-health-helpline>.

247 Information provided by GEO 21 January 2021.

248 *NSW Government: Communities and Justice*, 'Psychology Services' (Web Page) <https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/programs/principal-advisor-psychology/principal-advisor-psychology.aspx>.

249 Interviews with staff July 2018.

250 Corrective Services NSW, *Custodial Operations Policy and Procedures 3.7: Management of Inmates at Risk of Self Harm or Suicide* (16 December 2017) 19.

251 *Crimes(Administration of Sentences) Regulation 2014*, clause 285.

252 Corrective Services NSW, *Custodial Operations Policy and Procedures 3.7: Management of Inmates at Risk of Self Harm or Suicide* (16 December 2017) 33.

253 Corrective Services NSW, *Custodial Operations Policy and Procedures 3.7: Management of Inmates at Risk of Self Harm or Suicide* (16 December 2017) 19.

254 GEO, Junee Correctional Centre Operating Manual HRAT policy 5.8.s, CSNSW RIT p 26.

(ISP). The ISP details the management and placement of the inmate at risk. Principles of least restrictive care should be observed.[255] This means an inmate at risk may be accommodated in a cell with another inmate. However, if the inmate at risk also poses a risk to others, he or she will be placed on their own in an assessment cell. Assessment cells have transparent viewing panels and cameras to allow observation.

The RIT review date is 24 hours for inmates placed in an assessment cell, otherwise, the RIT determines the next review date. An inmate must not be placed in an assessment cell for more than 48 hours without the Governor's written approval.[256]

The GEO HRAT must include a mental health nurse (or a registered nurse if the mental health nurse is not available), a psychologist, and custodial staff. Operational staff involved in the inmate's daily routine, including employment overseers, may also attend. The at-risk inmate participates in a one-on-one discussion prior to the HRAT meeting, which maintains patient confidentiality and recognises the influence a group setting may have upon an inmate disclosing how they feel. The HRAT meeting is essentially a 'case review' and the inmate does not attend. The HRAT allows decision-making about plan modifications and discharge from the HRAT only with unanimous agreement of the nurses, correctional managers and medical practitioners involved.

The inspection team observed RIT and HRAT reviews where possible. It was noted that, while GEO policy must be consistent with CSNSW policy, there are some differences between the HRAT and RIT. These are outlined in the table below. The RIT model may and does differ with other private providers.

Table 10: Differences between GEO HRAT and CSNSW policies

	GEO HRAT	CSNSW RIT
Psychologist attendance compulsory	Yes	No
Inmate involvement	Inmate interviewed separately by all HRAT members prior to HRAT meeting. Inmate does not attend meeting.	Inmate is present for the meeting and is interviewed during the meeting.
Final decision-making regarding plan	Agreement of multidisciplinary HRAT team	Governor of the centre

These differences may have implications for consistency of practice across private and public providers in terms of how clinical information is obtained and used to make decisions about at-risk inmates. For example, an inmate interviewed by a RIT may be unwilling to disclose certain information in front of a group.[257] In contrast, the HRAT model maintains patient confidentiality by interviewing the inmate separately, which may allow more detailed information to be obtained.[258] Further, the compulsory involvement of a psychologist at a HRAT may support obtaining and sharing important clinical information about mental health need. In contrast, CSNSW psychologists do not routinely attend RITs, and they are not provided with RIT case notes. Some CSNSW psychologists suggested that the current RIT composition may benefit from having psychologists present to assist with interpreting behaviour and identifying mental illness.[259]

255 Corrective Services NSW, *Custodial Operations Policy and Procedures 3.7: Management of Inmates at Risk of Self Harm or Suicide* (16 December 2017) 5.

256 Corrective Services NSW, *Custodial Operations Policy and Procedures 3.7: Management of Inmates at Risk of Self Harm or Suicide* (16 December 2017) 11.

257 Interviews with staff June 2018.

258 Interviews with staff June 2018.

259 Interviews with staff May 2018.

A review of current RIT procedures may enhance the therapeutic potential of the RIT as an intervention. CSNSW advises that it regularly reviews its policy with the most recent review occurring on 12 March 2020.[260]JH&FMHN participate in all RIT reviews and decisions and support working collaboratively to review and improve the RIT process.[261]

An inquest by the NSW Coroner regarding a death in custody at the MRRC in 2015 recommended the centre develop local operating procedures relating to information sharing, discharge planning and psychiatric review in relation to RITs.[262]

Recommendation 3: CSNSW and JH&FMHN regularly review the Risk Intervention Team model including the staffing makeup of the Risk Intervention Team, therapeutic interventions, and review procedures in all correctional centres including privately operated facilities.

3.2.3 Specialised mental health facilities

The *Mental Health (Forensic Provisions) Act 1990 (NSW) allows for* a person imprisoned in a correctional centre while serving a sentence of imprisonment, or while on remand ,who is mentally ill, to be transferred to a mental health facility on the advice of two medical practitioners, one of whom is a psychiatrist.[263]

The person must be transferred back to the correctional centre within seven days unless the person is a mentally ill person or is suffering from a mental condition for which treatment is available in a mental health facility, and other care of an appropriate kind would not be reasonably available to the person in the correctional centre.[264]

This means that mentally ill inmates (including forensic patients) can be transferred to hospital settings other than the mental health facility located within the correctional setting.Transfers to mental health facilities outside the correctional setting requires careful consideration and negotiation between CSNSW, JH&FMHN and LHDs.

Generally, when an inmates' mental illness is so acute that it is unable to be managed at the correctional centre where they are accommodated they are referred to the Mental Health Screening Units (MHSUs) at the Silverwater Correctional Complex. However, the MHSUs are not declared mental health facilities and therefore cannot provide involuntarily treatment. The Mental Health Unit Ward of Long Bay Hospital 1 (LBH1) offers involuntary treatment within the correctional setting.

3.2.3.1 Mental Health Screening Unit, MRRC

The MHSU is a 43-bed inpatient unit focused on assessment, treatment and discharge of mentally ill inmates. It comprises a 13-bed high dependency unit including five assessment cells, and a 30 bed sub-acute unit. It is the only facility of its kind for male inmates in NSW. The MHSU is located inside the MRRC in western Sydney. The MRRC is the primary reception and remand facility for male inmates in metropolitan Sydney. It is an extremely busy centre, as demonstrated by the figures below.[265]

260 This review included the makeup of the RIT, which must include a custodial officer (of Senior Correctional Officer rank or above) designated by the Governor to convene the RIT. The RIT also includes a JH&FMHN and an Offender Services & Programs staff member. Information provided by CSNSW, 4 February 2021.

261 Information provided by JH&FMHN, 21 February 2021.

262 *Inquest into the death of M C* (State Coroner's Court of New South Wales, 2015/155740, 31 August 2018) 20.

263 Section 41, and 55 *Mental Health (Forensic Provisions) Act 1990.*

264 Section 56 *Mental Health (Forensic Provisions) Act 1990*.

265 Information provided by CSNSW, 8 April 2019.

Table 11: Custodial Movements in MRRC during 2018

Custodial movements, MRRC, 2018	
Maximum state	1199
New inmate receptions	8122
Inmates transferring in from another correctional centre	4021
Inmates transferred out to another correctional centre	6293
Inmates out to court (in person not AVL)	5955
Inmates discharged from custody	1554

The MHSU is jointly managed by CSNSW and JH&FMHN. Management includes a Nursing Unit Manager, Mental Health/Crisis Manager from CSNSW Offender Services and Programs, and an Assistant Superintendent. The unit is staffed by a multidisciplinary team including 5.9 FTE registered nurses seven days per week, 1 FTE Clinical Nurse Specialist Grade 2 (CNS2), 1 FTE Staff Specialist Psychiatrist; 1 FTE Psychiatry Registrar, 1 FTE Clinical Nurse Specialist Grade 2, psychologists, mental health nurses, probation and parole officers, Services and Programs Officers (SAPOs), education and custodial staff.[266]
All admissions to and discharges from the unit are conducted jointly by CSNSW and JH&FMHN.[267]

The MHSU can accommodate sentenced and remand inmates of any classification or protection status. Referral to the MHSU may occur upon initial reception to the MRRC. Referrals are also received from JH&FMHN health centres in adult male correctional centres across NSW.

Demand for a bed at the MHSU is very high and significantly greater than the number of beds available. Psychiatrists and the team decide who should be prioritised in a transparent and consultative process. A weekly bed demand meeting occurs via teleconference in order to prioritise referrals. NUMs and at times psychiatrists and psychologists, at referring centres may dial into this meeting to advocate for patients at their centre in need of acute care. This system can preference those who advocate best. The clinical need of the patient should always determine access to a bed in the MHSU.

To support the transition of inmates from the MHSU into the main accommodation units of correctional centres and manage demand for a bed in the MHSU, a 'step down' facility was created. Hamden is a 138-bed facility operating to an intensive community outpatient-style model. It is located at MRRC next to the MHSU.[268] Hamden is staffed by 4.4 FTE registered nurses, a Nurse Unit Manager, 0.4 FTE Staff Specialist Psychiatrist and 1 FTE Senior Career Medical Officer (SCMO) in Psychiatry a psychiatrist and a Senior Career Medical Officer in Psychiatry.[269] Hamden also receives services from psychologists and SAPOs. When Hamden is operating as intended it creates bed availability in the MHSU for mentally ill patients requiring acute care.

At the time of the inspection, JH&FMHN was unable to report on the numbers of inmates waiting for a bed at the MHSU. Monitoring waitlist numbers and the acuity of patients on the waitlist assists in quantifying the extent of the demand, which by anecdotal accounts appears to be significant. NSW is not alone in

266 Information provided by JH&FMHN, 30 April 2019; *NSW Government: Communities and Justice*, 'Mental Health Screening Unit' (Web Page) <https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/programs/at-risk-offenders/mental-health-screening-unit.aspx>.

267 *NSW Government: Communities and Justice*, 'Mental Health Screening Unit' (Web Page) <https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/programs/at-risk-offenders/mental-health-screening-unit.aspx>.

268 Information provided by JH&FMHN.

269 Information provided by JH&FMHN, 30 April 2019.

managing the demand for acute mental health services in the correctional system.[270] Western Australia currently employs a psychiatric risk rating for prisoners with risk or history of mental health need.[271] This system assists with both triaging the waitlist and quantifying the demand for services by type of service and location. Since the inspection, JH&FMHN have started recording and monitoring the waitlists for the Mental Health Screening Units, Hamden and Long Bay Hospital. These waitlists are monitored at the local, executive and Board Level.[272]

Recommendation 4: JH&FMHN record and monitor waitlists for the Mental Health Screening Unit to accurately assess demand for services.

3.2.3.2 Mental Health Unit, Long Bay Hospital 1

LBH1 is a declared mental health facility under the *Mental Health Act 2007*.[273] The Mental Health Unit at LBH1 currently consists of 'G' ward which has ten acute beds, and 15 beds each across 'E' and 'F' wards, which act as 'step-down' units from G ward. Most beds in G-ward are occupied by inmates who have become a risk due to medication non-compliance.[274] Inmates in G ward are not permitted to mix with others and are subject to management plans which are reviewed weekly or as needed. Medication can be enforced under the *Mental Health (Forensic Provisions) Act 1990.*[275] HPNFs are used in addition to management plans to ensure information relating to the management of an inmate in the mental health unit is recorded in a manner accessible to supervising custodial staff, as well as staff at the centre to which the inmate is discharged.

Inmates may be transferred to the Mental Health Unit from the MHSU or directly from a correctional centre. As with the MHSU, there was no waitlist system at the time of inspection. For the six-month period July – December 2018 there were between 6 and 11 patients in the MHSU waiting for a bed at the Mental Health Ward of LBH1.[276] Patients may be discharged from the Mental Health Unit to The Forensic Hospital, or a secure community-based mental health facility, or back to a correctional centre.

The inspection found that demand for custodial mental health beds outweighs supply. The 43-bed MHSU, 138-bed step-down Hamden unit and the 40-bed mental health unit at LBH1 is insufficient.

A similar finding was made by the NSW Parliamentary Inquiry into Parklea Correctional Centre. In December 2019 it was recommended that:

The NSW Government, over and above its recent investment in mental health services and infrastructure from 2018-19:

- provide sufficient additional resources to the Justice Health and Forensic Mental Health Network to enable it to meet the health needs of the New South Wales prisoner population, and their mental health needs in particular
- ensure that 60 more forensic beds are provided urgently
- ensure that there is sufficient investment in other mental health infrastructure for the prison population

270 Andrew Forrester et al, 'Mental Illness and Provision of Mental Health Services in Prisons' (2018) 127 *British Medical Bulletin* 101, 105; Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) 27-8.

271 Office of the Inspector of Custodial Services (WA), *Prisoner Access to Secure Mental Health Treatment* (September 2018) vi. https://www.oics.wa.gov.au/reports/prisoner-access-to-secure-mental-health-treatment/?doing_wp_cron=1590640258.0136439800262451171875

272 Information provided by JH&FMHN, 21 February 2021.

273 Declared under NSW Government, *Gazette: Special Supplement*, No 47, 16 April 2013, 981.

274 Interviews with staff March 2018.

275 *Mental Health (Forensic Provisions) Act 1990* s 76B; *Mental Health Act 2007* s 84.

276 Information provided by JH&FMHN, 18 February 2019.

throughout the state.[277]

Availability of mental health beds is not solely impacted by the demand for beds. It is also impacted by 'bed block'; where patients cannot access a bed because the bed is occupied by a patient who is ready to be discharged but is waiting for a bed to become available in another facility with a lower but appropriate level of care.

The inspection team was informed that Hamden accommodates many inmates waiting for a bed to become available in The Forensic Hospital.[278] This has limited the ability to move patients out of the MHSU into Hamden and reduce the waitlist for the MHSU.

The average length of stay in each ward of the Mental Health Unit, LBH1 for the period 2017-2018 is below.[279]

Table 12: Average Length of Stay in Mental Health wards

Average length of stay by ward, LBH1, 2017-2018	
G ward (acute)	44 days
E ward	154 days
F ward	144 days

Data for E and F wards suggests placement in the unit is not a short term measure. This may indicate there are inmates waiting for a bed to become available at The Forensic Hospital. Bed availability in the forensic hospital is impacted by a shortage of medium-secure forensic beds in the community.[280]

Bed block pervades the forensic and custodial mental health systems and is compounded by an insufficient number of beds at an adequate level of service within correctional facilities compared with demand.[281] This means the usual referral pathways are unable to operate as they should. Figure 12 below depicts the cascading impacts of 'bed block' including:

- Mentally unwell patients waiting at NSW correctional centres for a bed to become available at the MHSU
- Mentally unwell patients held in the MRRC's reception wing waiting for a bed at the MHSU
- Mentally unwell inmates at the MHSU or scheduled inmates at Hamden waiting for a bed to become available at LBH1 or the Forensic Hospital
- Forensic patients at LBH1 waiting for a bed to become available at The Forensic Hospital
- Forensic patients unable to transfer out of The Forensic Hospital due to a lack of medium-secure beds in the community

277 Portfolio Committee No. 4: Legal Affairs, Parliament of NSW, *Inquiry into Parklea Correctional Centre and Other Operational Issues* (Report 38, December 2018) 121, recommendation 14. NSW Government response to this recommendation is 'noted'.

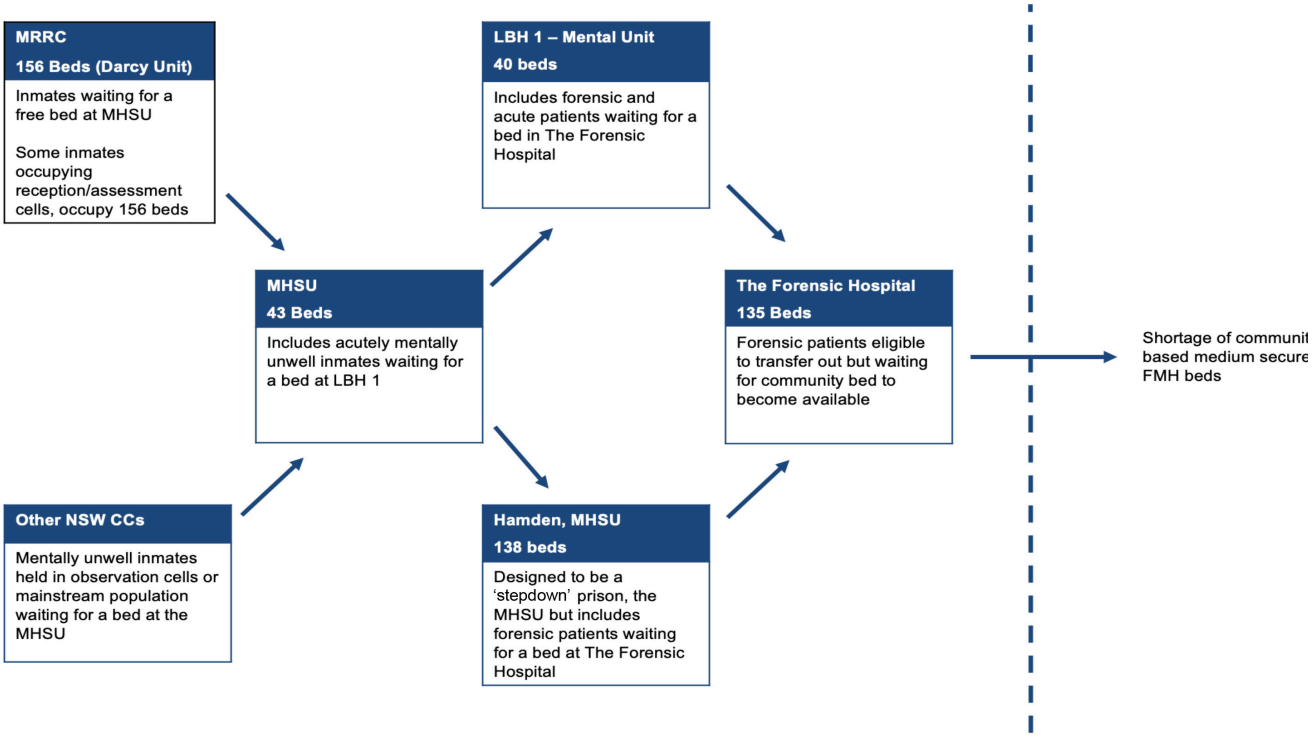
278 Patients who, in accordance with s.47(1)(a) of the *Mental Health (Forensic Provisions) Act 1990 (NSW)* have been found to be unfit to be tried for an offence, or been found not guilty by reason of mental illness, and ordered to be detained should be held at The Forensic Hospital, Malabar, or Long Bay Hospital, a gazetted correctional centre and declared mental health facility.

279 JH&FMHN data provided 18 February 2019.

280 The NSW Mental Health Commission notes 'far fewer beds and resources dedicated to helping forensic patients move to medium- and low-security facilities, and eventually to the community'; see Mental Health Commission of New South Wales, Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024 (15 December 2014) 81.

281 Interviews with Staff 2018.https://nswmentalhealthcommission.com.au/resources/living-well-strategic-plan-for-mental-health-in-nsw-2014-2024.

Figure 7: The impact of bed-block



One consequence of 'bed block' is that mentally unwell new receptions occupy beds in MRRC's clinically inadequate 156-bed reception and assessment Darcy Wing while waiting for a bed to become available in the MHSU or Hamden. This issue was previously identified in the 2015 ICS report Full House.[282]

CSNSW data for 2018 shows:[283]

- 36 inmates had a median length stay of 20 days in Darcy before transferring to the MHSU
- 327 inmates had a median length stay of 4 days in Darcy before transferring to Hamden

While these numbers reflect only a small proportion of the admissions to the MRRC in 2018, they are significant considering that Darcy comprises 156 beds in total including protection and segregation beds, and the MHSU is only 43 beds.[284]

A further impact, compounded by the relatively small number of mental health beds at the MHSU, is that forensic patients or acutely mentally unwell inmates are held at other correctional centres while waiting for a bed at the MHSU. These patients may be accommodated among the mainstream centre population, which may elevate their vulnerability and risk to others. Alternatively, they may be accommodated away from the mainstream population in observation or safe cells for their own safety or the safety of others, subject to regular checks upon their wellbeing.

The inspection team was made aware of the case of an inmate placed in segregation for several months at a correctional centre while awaiting transfer to the MHSU.[285] In another case, an inmate diagnosed as 'floridly psychotic' and referred to the MHSU was still awaiting transfer over one month later.[286]

282 The report found 'When there is a lack of vacant bedspace in the MHSU or the Hamden mental health step-down unit, this can backflow and result in inmates experiencing a prolonged stay in Darcy'. See: Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population' (Report, April 2015) 46.

283 CSNSW data, provided 8 April 2019.

284 Information provided by CSNSW January 2019.

285 Interview with Staff 2018.

286 Information provided by JH&FMHN 2018.

Although JH&FMHN must keep these inmates under daily observation and provide access to medical care[287], this is not conducive to the mental health of those inmates and it is resource intensive for correctional centres to keep those inmates safe. Housing inmates with a psychiatric disorder in observation cells or segregation cells at correctional centres was identified as a concern in the inquiry into Parklea Correctional Centre.[288]

The NSW Law Reform Commission has also considered this issue:-

'Taking into consideration the submissions of stakeholders to this review and the conclusions of previous reviews, we agree that forensic patients should not be detained in correctional centres. However, at this point we do not recommend a total prohibition on such detention. Until there are other options for detention of forensic patients that provide secure environments (where needed) together with treatment and services, a prohibition on detention of forensic patients in correctional centres would be impractical and could, if implemented, potentially be a threat to community safety.

The resolution of the problems that we have identified, and that have been noted by previous reviews, depends upon the provision of resources for facilities for forensic patients. Secure facilities are required, but also the range of facilities must be adequate so that forensic patients can be stepped down towards leave and release in a timely fashion.'[289]

In 2015, the ICS observed the competing demands of the remand and mental health functions at the MRRC and recommended that 'CSNSW relocates the mental health step-down functions currently undertaken at the MRRC to elsewhere in the estate to give primacy to the remand function'.[290] JH&FMHN supports consideration of a step-down unit for sentenced inmates at a sentenced prison, and a mental health step-down for unsentenced inmates at the MRRC.[291] CSNSW have advised this will be considered in collaboration with JH&FMHN should a more appropriate location and accommodation become available.[292]

Currently, JH&FMHN attend working groups convened by CSNSW about mental health services, and JH&FMHN consult with CSNSW on all policies impacting CSNSW.[293]

The inspection found that a review of the number, type and location of mental health beds across the correctional system is required. This is consistent with a recommendation from the NSW Coroner in July 2018:[294]

> *That CSNSW and Justice Health, undertake a review to determine whether the number of beds available for the treatment of mentally ill patients is adequate for the demand for such beds by those in the NSW correctional system and whether additional beds may be provided for those who are mentally ill and in need of various levels of mental health care. This review should include inpatient, step-down and low acuity beds Statewide.*

Given the number of remand inmates identified with high-risk mental health and the number of forensic patients in Hamden, the unit should remain open at MRRC.[295] However, consideration needs to be given

287 *Crimes (Administration of Sentences) Regulation* clause 289.

288 Parklea Inquiry Report p 117.

289 NSW Law Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: Criminal responsibility and consequences*, May 2013, pp. 302-314.

290 Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population' (Report, April 2015) recommendation 13.

291 Information provided by JH&FMNH October 2018.

292 Information provided by CSNSW June 2018.

293 Information provided by JH&FMHN.

294 *Inquest into the Death of Fenika Junior Tautuliu Fenika (Junior Fenika)* (State Coroner's Court of New South Wales, 2015/268972, 13 July 2018) 4.

295 JH&FMHN, Prison Mental Health Screener study, 2018 (unpublished); Information provided by JH&FMHN June 2019.

to creating another MHSU and step-down unit at a correctional centre for sentenced inmates, in order to better support the needs of sentenced inmates with acute mental health needs. This should alleviate some of the pressure on the MRRC. The challenge is to find a suitable location that will be able to attract and retain specialist staff required to service the high level of need.

CSNSW have recently announced an additional 217 step down and triage mental health beds at Long Bay Hospital and the Metropolitan Special Programs Centre. This will result in a net gain of 150 additional beds that will result in a total of 375 mental health beds in the system.[296] JH&FMHN have advised that it is anticipated that this work will be complete by June 2021 and are working closely with CSNSW on appropriate models of care.[297]

It is acknowledged that JH&FMHN and CSNSW have been working together in relation to collaborative care planning and have developed processes for information sharing and shared case management. JH&FMHN advise that it is working on a number of mental health initiatives in collaboration with CSNSW to improve access, treatment and outcomes for patients presenting with Mental Health issues.[298]

Recommendation 5: CSNSW and JH&FMHN develop a shared strategy for mental health given the size of demand and the resource implications for both agencies.

Recommendation 6: CSNSW increase the number of acute, sub-acute, step-down and mental health screening beds available in the system and collaborate with JH&FMHN and other stakeholders around appropriate models for operation

Recommendation 7: CSNSW consider locating sub-acute mental health beds for sentenced inmates at a correctional centre housing sentenced inmates, and step-down mental health beds for remand inmates at a remand centre

3.3 Population health

A population health unit within JH&FMHN oversees prevention, screening and management of Blood-Borne Viruses (BBVs) and Sexually Transmitted Infections (STIs), management of inmates who report sexual assault, environmental health, infection control, outbreak management, immunisation, health promotion, and harm minimisation.

Population health services are provided in JH&FMHN health centres by primary health nurses under the 'shared model of care'. Secondary clinical support is available through ROAMS, telehealth (where functional) and consultation with population health Clinical Nurse Consultants (CNC)s. The health centre at GEO-run Junee CC employs a dedicated full-time population health nurse. A hepatologist attends Junee CC three to four hours per month.[299]

Population health services are critical in correctional centres as Blood Borne Viruses (BBVs) are prevalent among prison populations.[300] JH&FMHN's early detection program aims to identify and minimise STIs and BBVs in custody. Upon reception, information about risk behaviours in relation to BBVs and STIs is obtained from inmates, and the value of early detection and treatment is provided. Good practice was observed at

296 Information provided by CSNSW, 4 February 2021.

297 Information provided by JH&FMHN, 21 February 2021.

298 Information provided by JH&FMHN, 21 February 2021.

299 Interview with staff 2018.

300 Australian Medical Association, *Position Statement on Blood Borne Viruses (BBVs)* (9 Jan 2017) 4; Department of Health (NSW): Centre for Population Health, *NSW Hepatitis C Strategy 2014-2020* (2014) 15 <https://www.health.nsw.gov.au/hepatitis/Pages/hepatitiscstrategy.aspx>. The AMA's position statement also states that prevalence is due to a range of factors including high rates of imprisonment for drug-related offences, the prevalence of people who inject drugs, the apparent availability of drugs and injecting equipment in prisons, the rate of pre-existing infection among prisoners, and unsterile injecting drug practices in prisons.

John Morony CC where all new remand receptions, including transfers from other centres, were offered BBV and STI screening upon arrival.

Testing is offered according to identified risk activities, symptoms or inmate requests. Primary health nurses may also screen when an inmate has come to the health centre for another matter. Inmates living with or newly diagnosed with a BBV or STI are referred to a Sexual Health and Immunology clinic.[301] Over the period 2017-2018, 11,959 inmates were screened for BBVs.[302] Of these, 9769 were tested.[303] In 2018-2019, 13665 inmates were screened for BBVs. Of these, 11552 were tested. Over the period 2019-2020, 13940 inmates were screened for BBVs. Of these, 11332 were tested.[304]

At the time of inspection Junee CC did not have population health screening and treatment targets. For the year 2018 Junee CC reported 1741 consultations for BBVs and STIs.[305] This number may have included screenings, hepatitis treatment and follow-up, however these were not counted separately. Improving recordkeeping about screening and treatment for BBVs may improve comparability of performance across public and private centres. This is important due to the generally high prevalence of BBVs and STIs among populations in contact with the criminal justice system.

All inmates in JH&FMHN health centres are offered immunisation against disease according to the NSW Health Immunisation Schedule, and inmates are offered the influenza vaccination from April to the end of September.[306] In the 2016-2017 period JH&FMHN provided influenza immunisation to 5355 patients.[307] In 2017-2018 this was provided to 6475 patients.[308] In 2018, Junee CC vaccinated 533 inmates.[309]

JH&FMHN has targets that are set by the NSW Ministry of Health for Hepatitis B vaccinations, BBV/STI screening and treatment targets for Hepatitis C. JH&FMHN' s Operations & Nursing and Population Health directorates work closely together to plan and coordinate local programs to meet targets.[310]

Since the inspection population health screening is now standard practice at Junee CC as well as Clarence CC and Parklea CC.[311]All private facilities now have consistent targets for the completion of population health screening and immunisation services.[312] Creating targets for private health providers is an important step forward in population health screening and treatment. However, the private facility targets and JH&FMHN targets are not the same. CSNSW and JH&FMHN should continue to work together to create consistent targets across public and private health providers.

Recommendation 8: Standardise targets for vaccinations and BBV/STI screening and treatment targets across public and private health providers

301 Justice Health and Forensic Mental Health Network, *Early Detection Program for Blood Borne Viruses and Sexually Transmissible Infections* (Policy 1.363, 6 April 2016) 3.

302 Information provided by JH&FMHN.

303 Information provided by JH&FMHN that not all patients screened require testing, 2018.

304 Source JH&FMHN Population Health September 2020.

305 Information provided by Junee CC 13 March 2019.

306 Justice Health and Forensic Mental Health Network, Immunisation of Patients (Policy 1.245, 26 September 2013) 7, pt 3.9.

307 Justice Health and Forensic Mental Health Network, 'Network Response to Inspector of Custodial Services (NSW) Data Request 3', item 15.

308 Justice Health and Forensic Mental Health Network, 'Network Response to Inspector of Custodial Services (NSW) Data request 1', Appendix, Item 16b: 'Performance report', item 7.

309 Information provided by Junee CC March 2019.

310 Information provided by CSNSW, 4 February 2021; Information provided by JH&FMHN, 21 February 2021; Information provided by GEO 21 January 2021.

311 Information provided by JH&FMHN, 21 February 2021.

312 Information provided by CSNSW, 4 February 2021.

3.3.1 Harm minimisation

To reduce the spread of BBVs and STIs in correctional centres, JH&FMHN and CSNSW undertake harm minimisation strategies. Harm minimisation as a principle acknowledges drug use and sexual activity as a part of society, and aims to reduce associated harms to individuals and communities.[313] Harm minimisation is supported by the *Guiding Principles for Corrections in Australia 2018* and is the foundation of Australia's *National Drug Strategy 2017-2026*.[314] Priority populations for harm minimisation strategies include people in contact with the criminal justice system, as well as Aboriginal people and people with mental health conditions, who are also overrepresented in custody.[315] This is because the transmission of HIV and Hepatitis C within the prison environment has high long term cost impacts on the health system both in custody and in the community.[316]

Hepatitis C is a particular focus for JH&FMHN. In the 2015 *Network Patient Health Survey*, 24.2% of females and 20.4% of males reported diagnosis of Hepatitis C.[317] JH&FMHN health centres must reach targets set by NSW Health in early detection of Hepatitis C, and treatment of Hepatitis C through Direct Acting Antiviral (DAA) medication.[318] JH&FMHN measures DAA treatment and uptake through treatment initiations, in line with NSW Health requirements.[319] In the 2016-2017 period, JH&FMHN assessed 6,164 patients for Hepatitis C, and 613 patients were commenced on DAAs.[320] In the 2017-2018 period, 1,167 patients were treated for Hepatitis C.[321] Over the period 2017-2018, 1,167 patients were treated for Hepatitis C.[322] The DAA program delivers significant longer term health benefits to the community. JH&FMHN should be commended on their significant work in this area, that has resulted in this important public health intervention that benefits not only the custodial environment but the broader community.

JH&FMHN health centres are also responsible for continuing antiviral medication for people living with HIV who enter custody.[323] JH&FMHN offer PrEP[324] in NSW adult correctional centres however records indicate that none was dispensed in the 2017-2018 financial year.[325]

However, longer-term population health interventions such as commencing inmates on DAAs can be a challenge at centres with a high remand population where inmates remain at the centre for short periods before being released to the community or transferred to other centres.[326]

313 Department of Health (Cth), *National Drug Strategy 2017-2026* (18 September 2017) 3; see also Corrective Services Administrators' Council, *Guiding Principles for Corrections in Australia* (February 2018) parts 2.1.2, 4.1.11.

314 Department of Health (Cth), *National Drug Strategy 2017-2026* (18 September 2017) 26-9.

315 Australian Government: Department of Health, *Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings* (Web Page, September 2014) <https://www1.health.gov.au/internet/main/publishing.nsf/Content/phd-hepc-guidelines-custodial-h>.

316 Australian Government: Department of Health, *Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings* (Web Page, September 2014) <https://www1.health.gov.au/internet/main/publishing.nsf/Content/phd-hepc-guidelines-custodial-h>.

317 Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 35.

318 See Department of Health (NSW), *2017-18 Service Agreement: An Agreement Between Secretary, NSW Health and the Justice Health and Forensic Mental Health Network for the period 1 July 2017-30 June 2018* (31 July 2017)23. DAAs became available on the Pharmaceutical Benefits Scheme (PBS) in March 2016 and are now available across NSW correctional centres according to individual clinical need. While medications on the PBS are routinely not subsidised for JH&FMHN, DAAs are classed as Schedule 100 Special needs/ high cost drug and JH&FMHN is considered as an outpatient prescriber of this specialist drug.

319 JH&FMHN data request 3, item 13.

320 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 55.

321 Justice Health and Forensic Mental Health Network, Network Response to Inspector of Custodial Services (NSW) Data request 1, item 57.

322 Justice Health and Forensic Mental Health Network, Network Response to Inspector of Custodial Services (NSW) Data request 1, item 57.

323 Justice Health and Forensic Mental Health Network, HIV Care Management and Treatment (Policy 1.242, 16 December 2013).

324 PrEP is an acronym that stands for pre-exposure prophylaxis. It involves HIV negative people taking antiretroviral drugs to protect them and prevent HIV infection.

325 Information provided by JH&FMHN 2018.

326 Interviews with staff 2018.

327 Harm Reduction Reference Group JH&FMHN and CSNSW Terms of Reference.

In 2017, JH&FMHN and CSNSW jointly established a Harm Reduction Reference Group (HRRG) in 2017 to advise on best practice harm reduction initiatives for people in custody.[327] Membership includes stakeholders from government, NGOs, peer-based advocacy organisations, and tertiary research institutions.[328]

A review by the HRRG identified the importance of accessible Fincol,[329] condoms, and educational resources for inmates. The review found that these were not always easily accessible at every centre.[330] Under Section 59 of the *Crimes (Administration of Sentences) Regulation 2014*, condoms and dental dams must be made readily accessible to all inmates.[331] The inspection team checked a random selection of condom machines at centres. All of those machines were operational and stocked.

People who inject drugs are overrepresented in Australian prisons.[332] Syringes are both contraband and currency in prisons.[333] Used syringes not only increase the risk of BBVs but also needlestick injury to inmates and staff. For this reason, NSW correctional centres provide Fincol and sharps disposal bins.

Despite the achievements of the HRRG, JH&FMHN nevertheless identify 'significant work to be done to continue to improve and strengthen harm reduction in NSW prison' and that 'implementing best practice harm reduction strategies that are acceptable to both organisations will remain challenging'.[334]

Population health researchers argue that:

> *incarcerating people who inject drugs in prison environments where drugs are widely available, BBV prevalence is disproportionately high and access to sterile injecting equipment is prohibited breaches basic human rights and international law that ascribes prisoners' rights to health care standards equivalent to those in the community*[335]

The National Drug Strategy 2017-2026 recognises that, within the three pillars of harm minimisation, NSPs are one strategy towards achieving safer injecting practices.[336] In respect of prisons specifically, in 1993, the World Health Organisation (WHO) recommended that, where preventative measures (including NSPs) were provided in the community, they should also be provided in prisons.[337] In 2004, the WHO stated that there was "a strong case for establishing and expanding NSPs in correctional facilities in many countries".[338]

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328 Harm Reduction Reference Group JH&FMHN and CSNSW Terms of Reference.

329 JH&FMHN, Custodial Health Conference Presentation. Fincol is a bleach product and inmates use it to clean illegally obtained syringes used for injecting drugs, see Suzanne Fraser, 'Introduction' in Fiona Poeder (ed) *Stories from the Other Side: An Exploration of Injecting Drug Use in NSW Prisons* (NSW Users and AIDS Association, 2013) 12, 18.

330 Information provided by JH&FMHN 2018.

331 Corrective Services NSW, Condoms and Dental Dams (Custodial Operations Policy and Procedures, Policy 6.7, 16 December 2017) 4.

332 Mark Stoové et al, 'Salvaging a Prison Needle and Syringe Program Trial in Australia Requires Leadership and Respect for Evidence' (2015) 203(8) Medical Journal of Australia 319, 319.

333 Michael Moore, 'The Availability of Sterile Needles and Syringes in Prisons as a Public Health Response' in Fiona Poeder (ed) *Stories from the Other Side: An Exploration of Injecting Drug Use in NSW Prisons* (NSW Users and AIDS Association, 2013) 35, 45.

334 Information provided by JH&FMHN 2018.

335 Mark Stoové et al, 'Salvaging a Prison Needle and Syringe Program Trial in Australia Requires Leadership and Respect for Evidence' (2015) 203(8) Medical Journal of Australia 319, 319.

336 Department of Health (Cth), *National Drug Strategy 2017-2026* (18 September 2017) 6.

337 *WHO Guidelines on HIV Infection and AIDS in Prisons*, WHO/GPA/DIR/93.3 (1993) 6 <https://www.who.int/hiv/idu/WHO-Guidel-Prisons_en.pdf?ua=1>.

338 World Health Organisation, 'Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users' (Evidence for Action Technical Papers, 2004) 30 <https://apps.who.int/iris/handle/10665/43107>.

339 Fernandes et al, 'Effectiveness of needle and syringe programmes in people who inject drugs – an overview of systematic reviews' (2017) 17:309 *BMC Public Health*, pp.1-15; Ferrer-Castro et al, 'Evaluation of a Needle Exchange Program at *Pereiro de Aguiar* prison (Ourense, Spain): A ten year experience' (2012) 14:1 *Rev Esp Sanid Penit*, pp.3-11,Information provided by CSNSW 4 February 2021.

CSNSW does not support the introduction of an NSP citing two reviews.[339]

No Australian jurisdiction has a prison based NSP (although it has been considered by jurisdictions including NSW, Tasmania and the Australian Capital Territory).[340] As a prison based NSP is not being introduced in NSW, alternative harm minimisation strategies need to be considered.[341]

Recommendation 9: CSNSW and JH&FMHN through the Harm Reduction Reference Group (HRRG) continue to consider the research and benefits of current and alternate harm minimisation approaches

3.3.2 Health promotion

Health promotion activities in correctional centres provide inmates with information about safety and decision-making, particularly in relation to BBVs, STIs and associated risk behaviours in custody. CSNSW policy requires a Health Survival Tips (HST) session to be delivered to inmates by Offender Services and Programs (OS&P) in every correctional centre.[342]

JH&FMHN has a dedicated Heath Promotion Manager. In addition, JH&FMHN's Health Promotion Leadership Committee develops health promotion activities, shares expertise, and ensures standardisation across JH&FMHN.[343]

JH&FMHN health centres provide information brochures on a variety of topics to inmates, in a range of languages and targeted at differing literacy levels. Patient resources and information that is developed by JH&FMHN is required to be reviewed for literacy levels and cultural appropriateness, including for Aboriginal patients.[344] Opportunistic health education also occurs during reception health assessments and attendance at primary health clinics. This is particularly important in correctional environments given prisoners are less likely to have accessed health services in the community.[345]

Junee CC employs a dedicated health promotion enrolled nurse who undertakes health promotion assessments and collaborates with the library manager to make a range of health promotion materials available to inmates in the library. Monthly 'themes' such as substance use or mental health in health promotion materials were aligned with the inmate TV system and a monthly inmate magazine. The Inspector supports this positive initiative.

Good practice in health promotion was also observed at John Morony CC, where inmates attend a five-day orientation course during their first week of incarceration, which included a presentation from offender services staff and health staff about the range of services available. A dedicated oral health promotion event held at Shortland CC in 2018 is also acknowledged, given the high rates of oral health need among inmates.

340 Recommendation to 'undertake further work to progress the implementation of the ACT Government policy of a needle syringe program in the AMC, consistent with services available in the ACT community, to reduce risks of blood borne virus transmission'; see ACT Health Services Commissioner, *Review of the Opioid Replacement Treatment Program at the Alexander Maconochie Centre* (Report, ACT Human Rights Commission, March 2018) 48-9. ; See Custodial Inspector (Tas), 'Inspection of Adult Custodial Services in Tasmania, 2017' (Care and Wellbeing Inspection Report, October 2018) 72; see Professor Dan Howard SC, Special Commission of Inquiry into Crystal methamphetamine and other amphetamine-type stimulants, Recommendation 97 (Report, January 2020) vol3,917.

341 Department of Premier and Cabinet (NSW), 'Interim NSW Government Response to the Special Commission of Inquiry into the Drug "Ice"' (2020) 2.

342 Corrective Services NSW, *Custodial Operations Policy and Procedures 6.5: Infectious and Communicable Diseases* (September 2017) 7, pt 1.5.

343 Information provided by JH&FMHN, 21 February 2021.

344 Information provided by JH&FMHN, 21 February 2021.

345 See, eg, Justice Health and Forensic Mental Health Network (NSW), *2015 Network Patient Health Survey Report* (May 2017) 43.

346 Justice Health and Forensic Mental Health Network, *Drug and Alcohol Service Provision* (Policy 1.040, 12 July 2017) 2.

Aboriginal Health and Oral Health services also reported conducting health promotion activities linked with Close The Gap Day and linked to NAIDOC week. Additional investment in health promotion would help to support implementation of health promotion strategies across all Correctional Centres.

Recommendation 10: Health service providers ensure health promotion activities for a range of literacy levels and cultural backgrounds take place at all correctional centres

3.4 Alcohol and other drugs

People entering prison have high rates of drug and alcohol use and dependence, including poly-substance abuse.[346] Further, they are likely to be at the more extreme end of the treatment spectrum compared to community patients due to higher rates of poly-substance use and comorbidity with mental health conditions.[347] The 2015 NPHS found 69% of respondents reported consuming alcohol in a hazardous way prior to incarceration, and two out of three reported a daily or almost daily substance abuse problem. JH&FMHN policy states that 'patients who continue treatment post release have lower levels of recidivism'[348] This highlights the importance of engaging inmates with these services in custody and having continuity of care in the community post-release.

JH&FMHN provide drug and alcohol services in NSW correctional centres to a medical model of intervention. Under the shared model of care, primary care nurses assess and manage intoxication and withdrawal during the reception and intake phases of incarceration, and provide Opioid Substitution Therapy (OST) to eligible inmates.[349] Specialist Clinical Nurse Consultants and Nurse Practitioners provide consultation, liaison, supervision and secondary clinical support. All JH&FMHN health centres may access specialist advice for withdrawal management on a 24-hour basis.

JH&FMHN screens for current and recent use of alcohol and other drugs upon reception.[350] Of particular concern with high levels of alcohol use, is that incarceration can lead to rapid detoxification from alcohol. This may lead to an increased risk of alcoholic seizures. Screening in police cells and reception centres focus on people at particular risk and treatment regimens are commenced utilising alcohol withdrawal medically approved protocols. Where a person is likely to be withdrawing from opioids or other substances, symptom mitigation treatments need to be initiated by qualified nursing staff.[351]

3.4.1 Opioid substitution therapy

A key drug and alcohol service available in correctional centres is continuation of OST. NSW correctional centres provide OST in the form of methadone syrup, buprenorphine wafers, suboxone film and long-lasting injectable buprenorphine.[352] OST dosing was observed in all centres inspected, and a high standard of safety and accuracy was demonstrated by all staff involved.

At the time of inspection, JH&FMHN policy stated 'All patients who enter the correctional system […] on an OST program are maintained on this treatment unless clinically indicated otherwise.'[353] Until 2014, all

347 Justice Health and Forensic Mental Health Network, *Drug and Alcohol Service Provision* (Policy 1.040, 12 July 2017) 2.

348 Justice Health and Forensic Mental Health Network, *Drug and Alcohol Service Provision* (Policy 1.040, 12 July 2017) 2.

349 Justice Health and Forensic Mental Health Network, *Patient Health Service Information* (2015) 6, 11-2.

350 Justice Health and Forensic Mental Health Network, *Health Assessments in Male and Female Adult Correctional Centres and Police Cells* (Policy 1.225, 12 July 2017) 2.

351 See JH&FMHN, Policy 1.320 Reception Assessment Process.

352 Suboxone is the commercial name for a pharmaceutical containing buprenorphine and naloxone, see Department of Health (NSW), *NSW Clinical Guidelines: Treatment of Opioid Dependence 2018* (Abbreviated version, July 2018) 4.

353 Justice Health and Forensic Mental Health Network, *Drug and Alcohol Services* (Policy 1.040, 22 July 2014) 3.

354 There is overwhelming evidence demonstrating a significant reduction in drug related mortality of up to 75% in patients retained in OST in the first four weeks post release from custody, Louisa Degenhardt et al , 'The Impact of Opioid Substitution Therapy on Mortality Post-Release from Prison: Retrospective Data Linkage Study' (2014) 109(8) *Addiction* 1306, 1310, 1312.

inmates entering custody were eligible for OST. As a consequence, JH&FMHN placed many inmates on an OST waiting list upon entry into custody, with the majority of patients being released before they could commence OST. Due to capacity issues within JH&FMHN and the broader community, the policy changed. The revised model was focused on managing the clinical risks for the most clinically vulnerable part of the prison population.[354] The principles of the model were: [355]

- All patients entering custody on an OST program remain on treatment unless clinically indicated otherwise.
- Any patient requesting to commence an OST program is clinically assessed / triaged and managed according to any clinical risks that are present.
- Patients who have priority status for entry onto the OST program (as per NSW Health policy and JH&FMHN policy), and are clinically appropriate to do so, are commenced on treatment as soon as practical. This includes pregnant women.
- Patients who are assessed as having significant medical risks and are clinically appropriate to commence on this treatment, are also fast tracked onto OST as soon as practical.
- All other applications are referred to as routine applications.
- Any patient that is unable to be commenced on this treatment whilst in custody is offered symptomatic management of any withdrawal syndrome they are presenting with and are referred to CSNSW D&A Programs where appropriate.

JH&FMHN reported that during the 2017-2018 period: [356]

- 1505 patients entered custody on an OST program and all were continued on treatment
- 383 inmates were commenced on OST by JH&FMHN for clinical reasons
- 1782 patients were released from custody on an OST program, and all had post release dosing arrangements organised to ensure continuity of care post release
- A total of 3172 individual patients were managed and clinically maintained on OST

Importantly, numbers alone do not accurately reflect the significant workload associated with administering OST and transferring OST between community and custody in a system with high numbers of inmates entering and leaving the custodial system, including after relatively brief periods of remand. Significant administrative work is often required to obtain valid confirmation of treatment in the community, dosage location and dosage levels. This is prioritised during the reception process and through the release of information process.

The process of daily dosing is also resource intensive and can extend to several hours in larger centres. Two dedicated staff are required, one of which must be a Registered Nurse. Primary health staff rotate between these and other health centre roles, rather than specialist drug and alcohol staff. All primary care staff are required to undertake orientation training in the process and procedures from OST administration prior to undertaking these roles.

Dosages must be verified by the two staff, the identity of the patient and the prescriber must be confirmed, and the dose being administered must be recorded in the Schedule 8 drugs of addiction log. Junee CC

355 Justice Health and Forensic Mental Health Network, 'Response to Request for Information: Inspector of Custodial Services (NSW) Inspection into the Provision of Health Services' (8 February 2019) item 21.

356 JH&FMHN response to ICS data request, item 19.

357 Information provided by JH&FMHN, 21 February 2021; Information provided by GEO 21 January 2021.

uses an automated 'Methadose' machine, which allows faster administration of methadone, more accurate recording, and requires only one nurse to administer. Custodial officers observe the OST administration process at all times and are responsible for confirming the individual patient has orally absorbed the medication. This observation period can be less than a minute for methadone, or between five and ten minutes for other OST therapies. Supervision is required to avoid diversion to unauthorised recipients. However, it has significant implications for patient flow, especially in larger centres with many inmates accessing OST on a daily basis. Some locations have commenced the utilisation of clinical support officers as the second/verifying officer (following training) where previously this had been a registered nurse or enrolled nurse undertaking the checking function. Until monthly intramuscular OST injections are normalised, there are few options to avoid diversion other than direct supervision.

Since the inspection, JH&FMHN and the private health providers have commenced long-lasting intramuscular buprenorphine injections, known as a depot, for people commencing OST in custody. Injectable Buprenorphine (Buvidal) is now available as a standard OAT (Opioid Agonist Therapy) medication in custody.[357] The injections last for one month.[358] Intramuscular OST should address the issue of diversion and the need for supervision, thus enabling health staff more time to provide other health services. This has also allowed increased access to OST for those inmates who do not fit the eligibility criteria at the time of inspection, and are therefore at an increased risk of continuing to use and engage in drug seeking behaviour in custody.

JH&FMHN has continued to increase OAT capacity with funding available for the financial year 2020-21. In 2019, approximately 10 per cent of patients were receiving OAT, this has since increased to approximately 17 per cent of the population. 1,507 patients have been initiated onto Buvidal since January 2019, with 1,186 new to treatment.[359]

JH&FMHN are to be commended for the significant work in fast tracking implementation of OAT. This will likely require additional resources to manage waitlists and enable timely clinical assessments for suitability for the OAT program. However, this will have substantial benefits for the custodial environment and public health more broadly.

Recommendation 11: CSNSW and JH&FMHN prioritise the full implementation of long-acting/ injectable OST.

JH&FMHN advise that all Drug and Alcohol medical treatments are available to patients regardless of sentencing status. This is important because many people enter custody withdrawing from illicit or legal substances (alcohol and nicotine).[360]It is important that inmates have access to withdrawal management services, including inmates in 24-hour court cell complexes and transit centres. It is also a requirement that all private providers have comprehensive withdrawal management services for alcohol and other drugs.[361]

The drug and alcohol services provided by JH&FMHN under a medical management model are supplemented by behavioural and psychological interventions provided by CSNSW. The services provided by CSNSW include case management, health promotion, relapse prevention and recovery programs such

358 Justice Health and Forensic Mental Health Network, *2018 Enabling Plan* (Version 2.0, July 2018) 10; Justice Health and Forensic Mental Health Network, Treatment for Drug Use, Fact Sheet for inmates, 8 May 2020.

359 Information provided by JH&FMHN, 21 February 2021.

360 ICS, *Inspection of 24-hour court cells in NSW* report, June 2018, p.47.

361 In accordance with the JH&FMHN Drug and Alcohol Procedures, the NSW D&A Withdrawal Clinical Practice Guidelines' and the National Clinical Guidelines for the Management of Drug Use During Pregnancy, Birth and the Early Development Years of the Newborn'.

362 JH&FMHN, Policy: Drug and Alcohol Services, (Policy 1.040, 12 July 2017) 2.

as Remand Addictions and EQUIPS Addiction.[362] Agencies may cross-refer inmates within centres.

The 2020 ICS reports, *Programs, Employment and Education Inspection* and *Women on Remand* identified the need for greater access to drug and alcohol programs for both remand and sentenced inmates.[363]

Table 13: Offender Participation in Alcohol and Other Drugs (AOD) programs delivered by Corrective Services NSW 2017-2020

IDATP Numbers		Total	Male	Female
2017/2018	Participants*	215	140	95
	Completion Rate	46.95%	47.67%	46.38%
2018/2019	Participants*	176	128	87
	Completion Rate	39.53%	21.21%	58.73%
2019/2020	Participants*	240	156	84
	Completion Rate	29.38%	24.76%	38.18%

*The participants are individuals who commenced during the period plus those who carried on from the previous period.

Table 14: Offender Participation in Alcohol and Other Drugs (AOD) AOD programs delivered by Corrective Services NSW 2017-2020

Offender participation in EQUIPS Addiction	2017/18	2018/19	2019/20
EQUIPS Addiction	1,534	1,900	2,002
Remand Addictions*	-	-	1,501

*Remand Addictions is a modified version of the EQUIPS Addiction program based on cognitive-behavioural therapy (CBT) principles and strategies.

Programs provided by GEO in the period November 2017 to October 2018 are outlined in Table 15 below:[364]

Table 15: Programs Provided in GEO in the Period November 2017 to October 2018

Correctional centre	Program	Number run in period
Junee CC	Addictions support group	n/a - ongoing
	EQUIPS Addiction	9
Parklea CC	EQUIPS Addiction	3

363 Inspector of Custodial Services, *Programs, Employment and Education Inspection,* February 2020, p.45,89.; Inspector of Custodial Services, *Women on Remand,* February 2020, p111; see also NSW Inspector of Custodial Services, Full House: The growth of the inmate population in NSW (Report, April 2015) 13; Recommendation 96 of the Special Commission of Inquiry into crystal amphetamine and other amphetamine-type stimulants is that the provision of drug treatment services and programs in custody should immediately be made the principal responsibility of Justice Health, see Professor Dan Howard SC, Special Commission of Inquiry into Crystal methamphetamine and other amphetamine-type stimulants, Report, January 2020) vol3,904.

364 CSNSW, 'Addiction Programs', Response to ICS request (7 December 2018) item 11.

365 Interviews with staff May 2018.

Of note, there are no Aboriginal-specific drug and alcohol programs available in NSW correctional centres. This is an area of difference compared to community health settings where Aboriginal-specific programs are available.[365] The ICS 2020 report *Programs, Employment and Education Inspection* recommended that Corrective Services NSW ensure that programs delivered in NSW correctional centres are culturally competent.[366]

Recommendation 12: A range of medical and non-medical drug and alcohol interventions should be available to all inmates regardless of sentencing status.

Recommendation 13: Accredited Aboriginal-specific drug and alcohol programs are made available in all correctional centres, with special attention to course content, facilitator, delivery setting, and retention strategies.

Recommendation 14: CSNSW Review the delivery of Remand Addictions and ensure delivery targets are met at correctional centres

3.5 Aboriginal health

As well as being overrepresented in prison, (25% in prison compared to 3% in the community in NSW), Aboriginal people have more complex health needs than non-Aboriginal people.[367] This is recognised at a national level through the National Agreement on Closing The Gap.[368] The Closing The Gap targets have been expanded to include the reduction of the incarceration rates of Aboriginal and Torres Strait Islander adults and young people.[369] Addressing mental health and substance abuse issues has been identified as a key driving factor for this reduction amongst adults.[370] The national acknowledgement of the interaction of criminogenic and health factors in the future wellbeing of Aboriginal people suggests priority needs to be given to considering dual approaches and specific initiatives in Aboriginal Health to Close The Gap. This includes the exploration of options to measure and report access to services in correctional centres, regardless of whether an inmate has been sentenced, including cultural safe health and mental health services, including health and disability assessment on entering prison as well as behavioural and specialist programs to address issues such as addiction.[371] Some NSW correctional centres have Aboriginal populations much higher than 25 per cent, as shown in Table 16 below.[372]

366 ICS, *Programs, Employment and Education Inspection* report, February 2020, p.15.

367 In 2015, JH&FMHN identified 'markedly divergent' health needs of Aboriginal inmates, including higher instances of schizophrenia, psychosis, alcohol abuse or dependence, and post-traumatic stress disorder among Aboriginal patients compared to non-Aboriginal patients; see Justice Health and Forensic Mental Health Network, 'Network Patient Health Survey: Aboriginal People's Health Report 2015' (Report, Department of Health (NSW), November 2017) xiii, 41.

368 Closing the Gap: In Partnership, *National Agreement on Closing the Gap* (July 2020) <https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf?q=0720>.

369 Closing the Gap: In Partnership, *National Agreement on Closing the Gap* (July 2020) 26 <https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf?q=0720>.

370 Closing the Gap: In Partnership, *National Agreement on Closing the Gap* (July 2020) 26 <https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf?q=0720>.

371 Closing the Gap: In Partnership, *National Agreement on Closing the Gap* (July 2020) 26 <https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf?q=0720>.

372 CSNSW, Aboriginal Offenders Report, 1 March 2019, p5.

373 Information provided by Justice Health and Forensic Mental Health Network, Integrated Care Service , May 2019.

Table 16: NSW Adult Correctional Centres with Aboriginal Population > 25% of Total Population

Centre	Percentage as at March 2019	Percentage as at February 2021
Bathurst (Maximum)*	-	35%
Bathurst (Medium male/female)	33%	37%
Bathurst (Minimum)	-	26%
Brewarrina (Minimum)*	100%	-
Broken Hill (Medium)	60%	60%
Broken hill (Minimum, male/female)	61%	45%
CDTCC (Minimum)	31%	-
Cessnock (Minimum, male/female)	30%	26%
Clarence (Maximum, male/female)*	-	37%
Dillwynia (Maximum, female)*	-	39%
Dillwynia (Medium, female)	33%	33%
Emu Plains (Minimum, female)	33%	28%
Grafton (Minimum, male/female)*	32%	-
Ivanhoe (Minimum)*	50%	-
Junee (Maximum)*	-	33%
Junee (Medium male / female)	32%	32%
Lithgow (Maximum)	26%	36%
Mid North Coast (Medium)	49%	34%
Mid North coast (Minimum)	29%	-
Mid North Coast (Maximum)	48%	40%
MSPC Area 2 (Maximum)	32%	35%
Shortland (Maximum)	36%	37%
Silverwater Womens CC	39%	45%
South Coast (Maximum)	29%	35%
Tamworth (Medium)	66%	67%
Tamworth (Minimum)	29%	45%
Wellington (Maximum)	55%	62%
Wellington (Minimum, male/female)	54%	35%

*Brewarrina, Grafton and Ivanhoe closed in 2020. Clarence opened in 2020. New maximum security accommodation was opened at Bathurst, Junee and Dillwynia in 2020.

3.5.1 Aboriginal Health Services currently provided in NSW correctional centres

At the time of inspection JH&FMHN's integrated care service included an Aboriginal Chronic Care program (ACCP) with a workforce of four FTE ENs and seven AHWs.[373] The program aims to identify eligible patients, increase referrals, improve wait times, ensure culturally appropriate services occur within custody and post-release, provide culturally appropriate care in custody, and advocate for patients and their families.[374] JH&FMHN has a KPI target with NSW Health around the number of patients accessing the ACCP. The Integrated care service aims to link inmates with LHDs and AMSs whilst in custody. The project is currently being piloted in Western NSW communities due to the concentration of Aboriginal populations in these areas.

Each JH&FMHN centre runs an annual 'Close The Gap Day' aimed at increasing Aboriginal inmates engagement with the health centres, offering health education and promotion information, and chronic health screenings.[375] Where a relationship with the local AMS exists, Close The Gap Day may also include in-reach services from Aboriginal Health Workers offering a similar service to the Medicare Benefits Scheme (MBS) item 715 Aboriginal and Torres Strait Islander Health Assessment. This involves a physical, psychological and social assessment of the person, and may recommend preventative health care or education where required. In 2016-2017, JH&FMHN held 32 Closing The Gap events across NSW, engaging 914 patients in a range of health promotion and health literacy initiatives.[376] JH&FMHN monitors patient attendance and feedback regarding these events.[377]

A positive initiative funded by JH&FMHN and NSW Health involves an Aboriginal family health worker from Waminda South Coast Aboriginal Health Service (WSCAHS) providing in-reach services at Silverwater, Dillwynia and Emu Plains Correctional Centres for at-risk women from the Shoalhaven area.[378] The worker attends the centres once per fortnight to provide culturally safe education, referrals and support for female inmates, and encourages engagement with JH&FMHN services. This allows continuity of care between community and custody. Positive initiatives such as this are commended, and innovative practices welcomed. Since the inspection JH&FMHN have entered into an MOU with WSCAHS to provide in reach and community support for Aboriginal women in custody.[379]

Other jurisdictions have invested in Aboriginal focussed through care models with transition and ongoing support from the Aboriginal Medical Service.

In the ACT, the Winnunga Nimmityjah Aboriginal Health Service (WNAHS) provides an autonomous Aboriginal health service with a culturally safe model of care inside the Alexander Maconochie Centre. The service is distinct from Justice Health and Aboriginal inmates may choose which service to access. Staff wear Aboriginal flag uniforms and are easily recognisable in the centre. Accredited behaviour change programs including Forensic dialectical behaviour therapy are adapted to be culturally relevant, and are delivered in a culturally safe way, including delivering sessions outside of a classroom environment, with an Aboriginal worker present.[380] WNAHS also provides services in the community, which streamlines continuity of care for inmates upon release.

374 Information provided by Justice Health and Forensic Mental Health Network, Integrated Care Service May 2019.

375 https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf?q=0720

376 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 56.

377 Information provided by Justice Health and Forensic Mental Health Network, 2019.

378 Justice Health and Forensic Mental Health Network, *Year in Review* 2018 ; 'Case Management Services' *Waminda: South Coast Women's Health and Welfare Aboriginal Corporation* (Web Page).

379 Information provided by JH&FMHN, 21 February 2021.

380 Visit to Alexander Maconochie Centre, ACT.

381 Interviews with staff 2018.

Despite having a large Aboriginal population (35%), at the time of inspection, Junee Correctional Centre had no culturally safe, relevant or appropriate health promotion activities occurring.[381] Training around Aboriginal culture, Aboriginal understandings of health and culturally responsive healthcare had not been provided to GEO health or custodial staff. GEO were aware of their obligation to implement the NSW Aboriginal Health Plan, however there was limited evidence of how this was occurring.[382] The centre relied on the local Aboriginal Health Service to provide pre-release transfer of care planning in relation to drug and alcohol services.

Privately and publicly managed custodial facilities should adhere to the same standards, and ensure that their operation is consistent with JH&FMHN policies. All health service providers are required to deliver health services that address the specific cultural and linguistically diverse health needs of all patients including Aboriginal and Torres Strait Islander custodial patients. JH&FMHN must adhere to the NSW Aboriginal Health Plan 2013-2023, NSW Good Health, Great Jobs 2016-2020, policy requirements of the Aboriginal Health Impact Statement and use the NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool. These policies and framework inform the strategic priorities of JH&FMHN in relation to Aboriginal health.[383]

Since the inspection, GEO has identified Aboriginal health services as a priority in its Three Year Health Services Action Plan.[384]

Recommendation 15: All health service providers bring their level of service in relation to culturally safe comprehensive primary health care for Aboriginal inmates in line with JH&FMHN policies and practices and equivalent community standards.

JH&FMHN is commended for the good work around Aboriginal chronic health screenings, Close The Gap Day and other emerging initiatives. It is acknowledged that the Aboriginal strategy and culture unit has undergone intensive development in recent years.[385] Recent achievements of the unit include recruiting to key roles, developing a strategy for engagement in the Aboriginal Community Controlled Health Sector, and developing the Aboriginal health workforce.[386] In 2018, JH&FMHN formed an Aboriginal health advisory committee including the Aboriginal Health & Medical Research Council, Ministry of Health, and the Department of Justice and Primary Health Network to strengthen interface with the AMSs in communities.[387] Priority areas include Western Sydney, Western NSW, the South Coast and the Hunter New England Region, as many Aboriginal inmates are discharged to these areas. This is important from a continuity of care perspective.

Notwithstanding these achievements, the inspection found there is significant work to be done to prioritise and embed culturally safe primary health care and social and emotional wellbeing services for Aboriginal inmates in NSW correctional centres. The existing interventions available to Aboriginal inmates in NSW prisons are not sufficient for achieving ongoing health education, engagement, and slowing the burden of chronic disease and poor health among Aboriginal people. The provision of culturally safe primary health care to Aboriginal inmates is an expectation of the NSW Health *Aboriginal Health Plan* policy and the Guiding Principles for Corrections in Australia.[388]

382 Information provided by GEO 2018.

383 Information provided by JH&FMHN, 21 February 2021.

384 Information provided by GEO 21 January 2021.

385 In 2017, an independent review of the JH&FMHN Aboriginal health strategy and culture unit made a range of recommendations to enhance delivery of Aboriginal health strategy and cultural leadership towards enhance cultural competency. See also Justice Health and Forensic Mental Health Network, *Year in Review 2016-2017* (Department of Health (NSW), December 2017) 63; Justice Health and Forensic Mental Health Network, Aboriginal Health Review and Justice Health and Forensic Mental Health Network, *2018 Enabling Plan*, July 2018 7.

386 Aboriginal health Forum 7 Nov 2018.

387 Aboriginal Heath Forum, 7 Nov 2018.

388 The 2018 *Guiding Principles for Corrections in Australia* states '*holistic health services are provided to Aboriginal and Torres Strait Islander prisoners that encompass mental and physical health; cultural and spiritual health needs; and recognise how connection to land, ancestry and family and community affect each individual*', see Corrective Services Administrative Council, *Guiding Principles for Corrections in Australia* (February 2018) 20, pt 4.1.10.

389 Health Workforce Australia, *Aboriginal and Torres Strait Islander Health Worker Project* 201129.

3.5.2 The Aboriginal workforce

An Aboriginal workforce is a key aspect of culturally safe primary health care. Embedding Aboriginal health workers in NSW correctional health centres is likely to improve engagement of Aboriginal inmates with prison health services. A comprehensive environmental scan of the Aboriginal and Torres Strait Islander health workforce in Australia found that 'the cultural distance between Aboriginal and Torres Strait Islander peoples and mainstream health services can influence the accessibility and appropriateness of health care.'[389] Further, the *Australian Government Aboriginal Health Plan* recommends a:

> *focus on building the mental health and social and emotional wellbeing workforce, including increasing the proportion of Aboriginal and Torres Strait Islander people working in this field, strengthening the Aboriginal and Torres Strait Islander community controlled health sector and developing the cultural competence of mainstream mental health services.'*[390]

The inspection team heard from Aboriginal inmates of the need for Aboriginal health workers or Aboriginal advocates at the health centres.[391] This includes Aboriginal doctors and dentists.

Privately and publicly managed facilities under existing contract arrangements are required to provide access to an Aboriginal and Torres Strait Islander Health Worker where available, whilst training and promoting the employment of culturally appropriate health care staff. In addition, they must ensure consultation with Community Aboriginal Health Services, including Aboriginal Medical Services to enhance health service delivery.[392]

The Inspections found an absence of Aboriginal health workers employed in health centres. There were limited numbers of approved positions within JH&FMHN for Aboriginal and Torres Strait Islander Health Workers/Practitioners and several vacancies. At the time of inspection, John Morony and Shortland Correctional Centres had funding for an Aboriginal health worker role, but the role had not been filled.[393] JH&FMHN are aware of this challenge and are currently undertaking development of their Aboriginal workforce.[394]

Since the inspection Junee CC has successfully recruited a dentist who is also employed by the Riverina Medical and Dental Aboriginal Corporation to embed a culturally sensitive dental service to Aboriginal patients.[395] Where JH&FMHN and private health providers cannot provide Aboriginal specific services, it is vital that they engage with local Aboriginal medical services. It is acknowledged that models of partnership with Aboriginal medical services have been trialled in the past. The sustainability and effectiveness of these models have provided challenges. This is not a reason to not re-explore this issue given the revised Close The Gap targets, and emerging self-determination environment.[396] The National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA) notes the range of healthcare provided by Aboriginal Health Workers and Aboriginal and Torres Strait Islander Practitioners. These roles are developing, and

390 Department of Health (Cth), *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* p 20.

391 Interviews with inmates 2018.

392 Information provided by CSNSW 4 February 2021.

393 Interviews with staff 2018.

394 Currently there is a regional base system utilising a Hub and Spoke Model for Aboriginal Health Workers. These staff work in collaboration with the Aboriginal Chronic Care Programs staff. As part of JH&FMHN's Aboriginal Workforce Plan 2019 – 2022 Aboriginal Cadets are recruited for placements in health centres annually. In 2020 two cadets were placed at Francis Greenway Complex and one at Reiby Youth Justice centre. In addition all clinical and operational nursing positions continue to be advertised for targeted recruitment. There is also collaboration with key Aboriginal groups and organisations across the state to help attract talent, Information provided by JH&FMHN 21 February 2021.

395 Information provided by GEO 21 January 2021.

396 JH&FMHN is exploring partnerships with the AMS, Information provided by JH&FMHN 21 February 2021.

397 National Aboriginal and Torres Strait Islander Health Worker Association, National Framework for Determining Scope of Practice for the Aboriginal and/or Torres Strait Islander Health Worker and Health Practitioner Workforce (2018) 4, 9-10.

the type of activities that a health worker or health practitioner can undertake depends on the type of supervision and support available.[397] The clinical and cultural support available to Aboriginal health workers in correctional health centres will therefore be a key consideration for custodial health providers.[398]

Recommendation 16: JH&FMHN and private health providers staff all correctional centres with Aboriginal and Torres Strait Islander Health Workers/Practitioners, and identified Aboriginal health staff and collaborate with relevant peak bodies regarding clinical and cultural support

Recommendation 17: JH&FMHN and private health providers continue to explore partnerships with Aboriginal Medical Services and funding models to support provision of culturally safe primary health care

In 1991 the Royal Commission into Aboriginal Deaths in Custody noted that 'one of the major obstacles to further involvement of the [Aboriginal] Medical Services has been the limited amount of resources available to extend their operations beyond current limits'.[399] Resourcing remains a barrier to the availability of Aboriginal health workers in correctional centres.[400] Currently, Close The Gap-related health services provided in NSW correctional centres are predominately delivered by JH&FMHN health centres and occasionally involve the in-reach services of a local Aboriginal Medical Service (AMS) where a relationship exists.

Screening and health promotion services provided to inmates by the local AMS, such as the MBS Item 715 Aboriginal and Torres Strait Islander Health Assessment, cannot be claimed by the AMS against the MBS entitlement because inmates are not eligible for Medicare.[401] The ability to claim MBS for in-reach services by AMSs may foster greater engagement of AMS in-reach support, build trust between Aboriginal patients and AMSs and encourage continuity of care for Aboriginal patients with their local AMS post-release. This may be achieved through allowing Aboriginal and Torres Strait Islander inmates to access Medicare, or have access to particular MBS Item numbers. Indeed, the ACT Health Services Commissioner recently recommended that Aboriginal and Torres Strait Islander detainees be offered annual Aboriginal Health Assessments, and that ACT Health seek an exemption to allow a Medicare rebate for these assessments occurring at the AMC. [402] JH&FMHN and CSNSW should seek access to Medicare rebates for Aboriginal inmates and/or MBS items for Aboriginal and Torres Strait Islanders.[403]

Recommendation 18: Advocating for a trial for access to Medicare for Aboriginal inmates and/or MBS items for Aboriginal and Torres Strait Islanders where the current services are unable to meet comparable community service models for Aboriginal and Torres Strait Islander people in the community.

398 The Coordinator Aboriginal Workforce Development provides cultural support to existing Aboriginal staff. Aboriginal staff have been approved to engage in external cultural supervision to support them in their roles, Information provided by JH&FMHN 21 February 2021.

399 See *Royal Commission into Aboriginal Deaths in Custody* vol 3, 24.4.49.

400 Interviews with JH&FMHN and Tamworth Aboriginal Medical Service 2018 and 2019.

401 Medicare is not provided to prisoners on the assumption that health care is being provided by states and is equivalent to community standard. See s 19(2) of the *Health Insurance Act 1973 (Cth).*

402 ACT Health Services Commissioner, Review of the Opioid Replacement Treatment Program at the AMC (Report, March 2018) 4.

403 JH&FMHN is engaging with Winnunga Nimmityjah Aboriginal Health Service (WNAHS) to explore the service model that includes MBS items for correctional facilities in the ACT, Information provided by JH&FMHN, 21 February 2021...

404 Indigenous Allied Health Australia, *Policy Position Statement: Culturally Responsive Healthcare* (2015) 1,2.

3.5.3 Embedding cultural safety

Increasing the Aboriginal workforce is critical for the cultural safety of health services provided to Aboriginal inmates. Equally important is a culturally responsive mainstream workforce. Culturally responsive health care is:

> *an extension of patient centred care that includes paying particular attention to social and cultural factors in managing therapeutic encounters with patients from different cultural and social backgrounds […] a cyclical and ongoing process, requiring regular self-reflection and proactive responses to the person, family or community with whom the interaction is occurring[…] Being culturally responsive places the onus back onto the health professional to appropriately respond to the unique attributes of the person, family or community with whom they are working*[404]

The Inspector acknowledges and supports the work of the JH&FMHN Aboriginal Strategy and Culture Unit and their inclusion in the executive level of the organisation.

The compulsory JH&FMHN training module 'Respecting the Difference' is a positive initiative for developing the cultural competency of staff. JH&FMHN are reviewing the delivery model for 'Respecting the Difference' to 'enhance and embed culturally safe and inclusive workplaces throughout the Network'.[405]

Despite having a large Aboriginal population (35% at the time of inspection), there was no evidence of staff training around Aboriginal culture, and Aboriginal understandings of health and culturally responsive healthcare to GEO health or custodial staff. Cultural awareness training is now provided to all staff at Junee Correctional Centre.[406]

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) recommends a nationally consistent approach to embedding cultural safety across nursing and midwifery, supported by standards, benchmarking, and accreditation.[407]

Recommendation 19: All custodial and health service providers increase the cultural competency and cultural safety of their workforce, and support this with ongoing training, supervision and leadership

3.5.4 Connection to culture

Connection to culture as a protective factor in Aboriginal mental health and social and emotional wellbeing has been recognised by JH&FMHN.[408] The 2015 *Aboriginal Peoples Health Report* by JH&FMHN found that:

> *90.1% of Aboriginal men and 80.9% of Aboriginal women reported identifying with a particular Aboriginal people or country, including 78.3% of men and 73.6% of women from within NSW*
>
> *Almost all Aboriginal participants reported feeling accepted by other Aboriginal people, and being proud of their Aboriginality*[409]

405 Justice Health and Forensic Mental Health Network, *2018 Enabling Plan* (July 2018) 7, pt 3.2,

406 GEO has partnered with experts from the Centre for Cultural Competence Australia to offer GEO health services staff cultural competence training,Information provided by GEO 21 January 2021.

407 Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), *Position Statement: Embedding Cultural Safety Across Australian Nursing and Midwifery* (2017) 1-3.

408 Justice Health and Forensic Mental Health Network, 'Network Patient Health Survey: Aboriginal People's Health Report 2015' (Report, Department of Health (NSW), November 2017) 24.

409 Justice Health and Forensic Mental Health Network, 'Network Patient Health Survey: Aboriginal People's Health Report 2015' (Report, Department of Health (NSW), November 2017) xii, 24.

410 Stephane Shepherd, 'Can a Connection to Culture Reduce Mental Illness Symptoms and Risk for Future Violence?' (2018) 54(2) *Australian Psychologist* 151, 153.

Evidence from Victoria demonstrates that 'cultural identity and cultural engagement are prominent protective factors for mental health symptoms and violence for Indigenous people in custody'.[410] The study found 'participants with higher levels of cultural engagement took longer to violently re-offend' and cultural engagement was significantly associated with non-recidivism. [411] The authors assert 'a greater need for correctional institutions to accommodate Indigenous cultural considerations.'[412]

Connection to culture is an important health promotion and risk prevention strategy aligned with CSNSW's priority to reduce reoffending. Custodial providers thus have a role to play in meeting the health and wellbeing needs of Aboriginal inmates through supporting connection to, or re-engagement with, culture. Examples include cultural activities, Aboriginal Inmate Delegate Committees (AIDCs) and Social and Emotional Wellbeing (SEWB) initiatives.

CSNSW's Aboriginal policy and strategy unit provides some dedicated Aboriginal services. While specialised services are important, more cultural programs and activities need to be made available to the whole Aboriginal inmate population. Aboriginal inmates expressed a strong interest in participating in cultural programs and activities.[413] While CSNSW policy provides for Aboriginal community mentors and elders to provide cultural support for inmates, there was no evidence of this occurring at the centres we inspected.

AIDCs are important voices for representing the health, wellbeing and cultural needs of Aboriginal inmates. Correctional centre senior management should foster AIDCs and their ideas for cultural initiatives. The AIDC at Junee CC appeared to have a fairly stable membership and met regularly with senior management. Some good practice was identified at John Morony CC where, during a meeting with an Aboriginal delegate and Aboriginal inmates, the Governor recognised the importance of connection to culture, and committed to providing Aboriginal inmates a dedicated space for peer support in the immediate future.[414]

At the time of writing, CSNSW advised that its 2014 'Strategy for supporting Aboriginal Offenders to desist from re-offending' was being updated to incorporate the Premier's priority to reduce reoffending.[415]

In Victoria, an *Aboriginal Social and Emotional Wellbeing Plan* was jointly developed in 2015 by Corrections and Justice Health. The plan acknowledges that Aboriginal people continue to be significantly over-represented in prison, experience poorer mental health than non-Aboriginal people, and aims to improve health and justice outcomes for Aboriginal people in prison.[416] The plan involves:[417]

- Investing in programs and services to build resilience, reinforce positive cultural identity, and address trauma
- Improving cultural training across the prison system and increasing the number of Aboriginal people participating in the prison workforce

411 Stephane Shepherd, Rosa Delgado and Yin Paradies, 'The Impact of indigenous cultural identity and Cultural Engagement on Violent Offending' (2018) 18(1) *BMC Public Health* 50, 50.

412 Stephane Shepherd, Rosa Delgado and Yin Paradies, 'The Impact of indigenous cultural identity and Cultural Engagement on Violent Offending' (2018) 18(1) *BMC Public Health* 50, 55.

413 Interviews with inmates 2018.

414 Interviews with staff and inmates 2018.

415 Information provided by CSNSW August 2020.

416 Justice Health and Corrections Victoria, *Aboriginal Social and Emotional Wellbeing Plan* (2015) 2, 6. The Plan developed out of the Victorian Aboriginal Justice Agreement (AJA). NSW does not currently have an AJA however the 2018 Australian Law Reform Commission's *Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* recommended that all states and territories develop and implement Aboriginal Justice Agreement (AJAs); see Australian Law Reform Commission, *Pathways to Justice: An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No 133, December 2017) 499, recommendation 16.2.

417 Justice Health and Corrections Victoria, *Aboriginal Social and Emotional Wellbeing Plan* (Department of Justice and Regulation (Vic), March 2015) 4 <https://www.corrections.vic.gov.au/publications-manuals-and-statistics/aboriginal-social-and-emotional-well-being-plan>.

418 Information provided by JH&FMHN, 21 February 2021.

- Recognising the central role that cultural and spiritual identity has in mental health and wellbeing
- Working in partnership with Aboriginal community organisations to support prisoners to maintain their health while in prison and upon release into their communities

An equivalent plan in NSW would be a positive step in acknowledging and addressing the burden of poor mental health, disadvantage and incarceration among Aboriginal people.

The NSW Health Aboriginal Mental Health and Wellbeing Policy is due to be released in 2021. JH&FMHN will then commence work to implement the policy.[418]

Recommendation 20: CSNSW and JH&FMHN, and the private custodial and health providers, develop an Aboriginal social and emotional wellbeing plan to support connection to culture and social and emotional wellbeing for Aboriginal inmates.

3.6 Medication

JH&FMHN provide pharmaceutical services to all correctional centres commensurate to those available in the wider community. Prescription, dispensing, administration, supply, storage, disposal and distribution of all medications complies with NSW policy. Schedule 4D (S4D) or Schedule 8 (S8) drugs must be stored and locked in a dedicated safe within the health centre.[419] JH&FMHN's pharmacy facilitates deliveries of pharmaceuticals to each centre. After-hours access to medications can also be facilitated through public hospitals and some community pharmacies.[420]

The need for prescription medication may be identified upon reception by the patient reporting a list of current prescribed medication, and confirmation of these medications by the patient's GP in the community. Alternatively, medication may be prescribed by a GP or NP following a consultation.

All medications, new or continuing, require an approved prescriber to complete the medication order/prescription, either in person or remotely under some circumstances. If the GP or NP is unavailable, all prescriptions require handwritten scripts into the medication chart as there is no electronic prescribing or medication management system available. The ROAMS is utilised by centres for rewriting prescriptions, or prescribing continuation of medications from the community, if a GP or NP is not available. JH&FMHN's Chief Pharmacist is available after-hours for any medication related issues.

The impact of prescribing, medication management and medication administration on patient care were observed by the inspection team in each location. This medication administration cycle requires daily focus from the health workforce, with a workload that cannot be underestimated, and is one of the most significant tasks undertaken within JH&FMHN. Medication is made available to inmates in several ways. Modes of dispensing include supervised, delayed, or monthly self-administration packs. The mode will depend on the security classification of inmates, protection status, the type of medication, and any other contemporaneous operational factors.

Supervised medication involves inmates attending the health centre in person, where medication is dispensed by medication administration credentialled ENs or RNs who verify the inmates' identity before dosing. Supervised medication may occur twice daily for some inmates. In some cases, a single dose of medication will be provided to an inmate in the morning for self-administration later that afternoon.[421]

419 Corrective Services NSW, Medications (Custodial Operations Policy and Procedures, Policy 6.8, 16 December 2017) 7.

420 Justice Health and Forensic Mental Health Network, *Clinical Services Provided by JH&FMHN* (Policy 1.080, 4 November 2014) 4.

421 Interviews with staff 2018.

422 Corrective Services NSW, Medications (Custodial Operations Policy and Procedures, Policy 6.8, 16 December 2017) 5.

This is referred to as 'delayed administration' and is allowable under JH&FMHN protocols. Correctional officers may be required to provide an inmate with necessary medication if health staff are not on duty.[422]

Inmates on the monthly medication pack program may keep their monthly supply of medication in their accommodation area. All inmates on this program are risk-assessed for eligibility, and provided information on drug interactions, safe storage and handling, blood testing, metabolic monitoring, counselling and consumer information. Medications likely to be misused or diverted will not be provided in the packs. A current and accessible list of inmates with self-medication packs is maintained for each accommodation area, and custodial staff are responsible for ensuring inmates are not hoarding or trading medication.[423] Sentenced inmates or those on long-term remand are more likely to commence self-administration, as their accommodation and routine is less likely to be disrupted compared to short-term remand inmates.[424] Expansion of the JH&FMHN pharmacy building in 2016/17 enabled a 25% increase in enrolments to the patient self- medication program.[425] Continued expansion of self-administration to eligible inmates is positive because it normalises self-management behaviours required upon release. It also enables nurses to spend less time dispensing daily medication and more time conducting health assessments and running primary care clinics. This in turn may have a positive impact on waitlists for health services.

Inmates travelling to court will have necessary medication administered by CSNSW staff, from a specially packed envelope prepared by JH&FMHN staff. If the envelope contains a scheduled medication, nursing staff are required to obtain a record of receipt when the security bag containing the medication envelope is handed to a correctional officer.[426] This is not ideal, but necessary due to JH&FMHN staff not being present in all 24 hour court complexes.[427]

The 2015 ICS report *Full House* identified significant time and logistics required for distributing large volumes of prescription medicine to inmates, often at the cost of seeing patients.[428] At one of the centres inspected for the current report, health centre staff emphasised the significant investment of time required each day for dispensing medication.[429] Given the significant and complex needs of the inmate population and the highly securitised nature of the correctional environment, it is important to reduce nurse time required for administering medication through new or innovative solutions.[430] This would not include using CSNSW staff, who are not trained to dispense medications.

A medication sachet pilot was commenced at the MSPC, Long Bay in 2018. The pilot involves a state-of-the-art machine automatically packing individual pills in to sealed sachets and labelling with the drug and the inmates name. JH&FMHN advise the machine manages about 2,000 patient medications however there is capacity to increase this.[431]While a pharmacist is still required to refill canisters and maintain the software, the machine saves time previously spent on manual webster packing. At the time of writing, the trial was ongoing and evaluation had not yet occurred.[432] At Junee CC patients are encouraged and empowered to manage their own health through the implementation of medi-sachets. This practice aligns with community

423 Corrective Services NSW, *Medications* (Custodial Operations Policy and Procedures, Policy 6.8, Version 1.0) 9.

424 Interviews with staff 2018.

425 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 57.

426 Corrective Services NSW, *Medications* (Custodial Operations Policy and Procedures, Policy 6.8, Version 1) 4.

427 Inspector of Custodial Services (NSW), *Inspection of 24-hour court cells in NSW*, June 2018, pp. 3-4 and Recommendation 16: The Inspector recommends that JHFMHN and CSNSW jointly monitor inmate reception numbers and patient flows to ensure adequate health coverage of 24-hour court cells with locations and times to be negotiated between CSNSW and JHFMHN, depending on the distinct needs of each location.

428 Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population' (Report, April 2015) 53.

429 Interviews with staff 2018.

430 Note:this would not include using CSNSW staff, who are not trained to dispense medications.

431 Information provided by JH&FMHN December 2019.

432 Information provided by JH&FMHN 2018.

433 Information provided by GEO 21 January 2021.

norms and JH&FMHN standards.[433]

It is important from a service efficiency and effectiveness perspective to reduce the time and resources dedicated to prescribing and dispensing medication to enable the redirection of those resources to seeing patients and addressing the existing and emerging health needs of inmates in their care. It is acknowledged that JH&FMHN are committed to improving the systems for medication management.

Recommendation 21: JH&FMHN continue to explore options for saving time on dispensing medication to allow nursing staff to focus on health assessments and primary health clinics

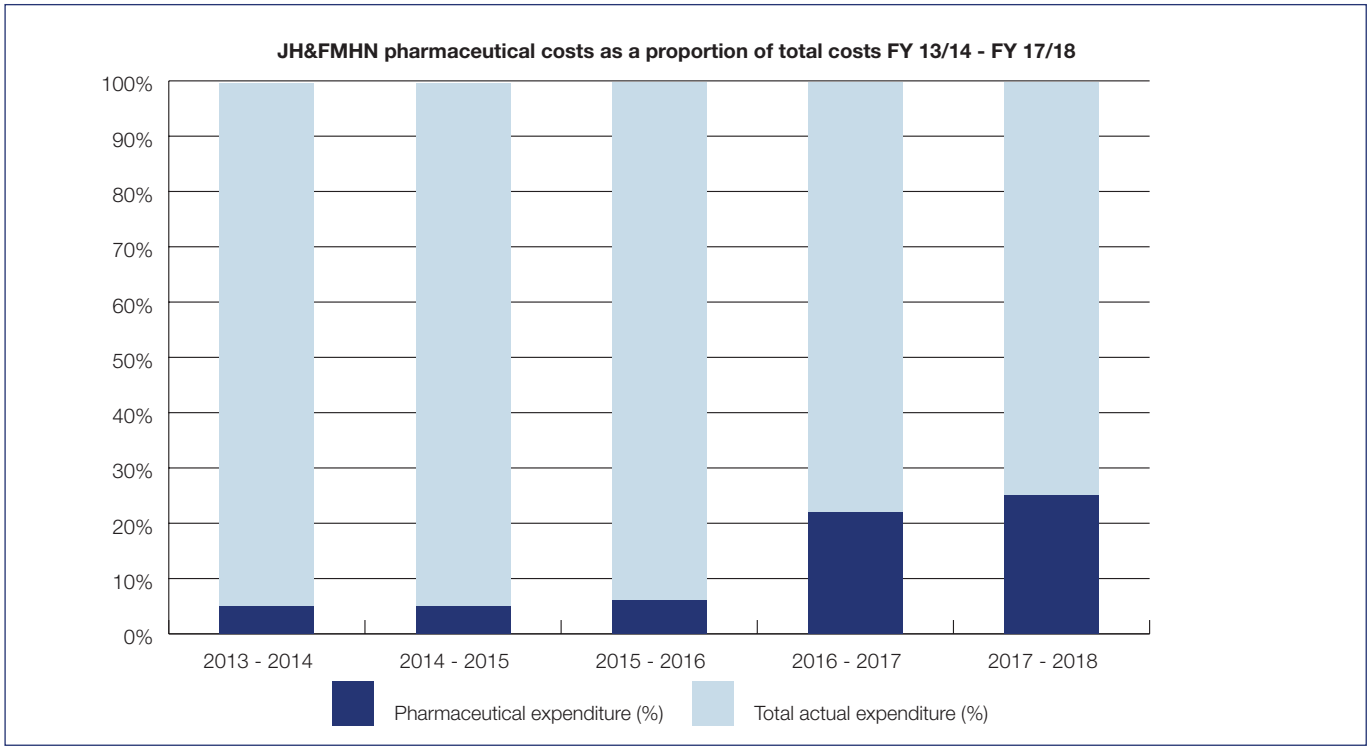
JH&FMHN's pharmaceutical expenses as a proportion of its total expenses, is represented below. JHFMHN attributes the increase depicted in figure 12 to Hepatitis C direct acting antiviral medications. JH&FMHN is an outpatient prescriber for these highly specialised and expensive S100 drugs.

JH&FMHN provided the following information about medication:[434]

- In the 2016-2017 period, 1762 inmates received highly specialised drugs.[435]
- At 16 November 2018, 630 inmates were receiving sachet-packed medication and 1624 inmates were on self-medication program.
- The exact number of inmates on antipsychotic medication changes daily.[436]

Figure 8 below shows JH&FMHN's increasing expenditure on pharmaceuticals.

Figure 8: JH&FMHN Pharmaceutical Costs as a Proportion of Total Costs in the period FY 2013-14 to FY 2017-18. Source: JH&FMHN response to data request 2, item 5, provided 18-2-2019



434 Information provided by JH&FHN pertains to different time periods as medication changes daily and recordkeeping of different types of medication is not consistent.

435 JH&FMHN advise this is not able to accurately break down into month and health centre.

436 Information provided by JH&FMHN.

437 Information provided by JH&FMHN September 2020.

The cost of pharmaceuticals is rising as a proportion of total costs because of the rising cost of pharmaceuticals and the increase in inmate numbers. The increase in pharmaceutical costs has exceeded increases in the pharmacy budget. JH&FMHN advise that the cost of pharmaceuticals was $3.2million over budget in 2018-19.[437]

Given the generally poor health of NSW inmates, the increasing inmate population and the high demand for costly medications, it is important that JH&FMHN is resourced accordingly.

Recommendation 22: JH&FMHN is funded commensurate to the demand for pharmaceutical expenses

The management of medication at Junee CC was found to be generally consistent with systems observed at JH&FMHN centres. At the time of inspection at Junee CC, nurses visited accommodation units with a trolley of medications and inmate health records to dispense medication to inmates. In July 2018 GEO's clinical governance team was instructed by GEO to review and report on Junee CC's medication administration in relation to consistency with JH&MHN guidelines, local workforce capability, impact of proposed and existing infrastructure, and any other practices relevant to medication administration.

Since then, purpose-built satellite dispensing rooms have been constructed for the administration of medications within the existing inmate accommodation units. The satellite dispensing rooms have improved the efficiency of administering medications as well as significantly alleviated risks associated with transporting medications around the Units on trolleys. This practice also contributes to improving staff safety.[438]

3.7 Oral health

The burden of oral health disease among inmates is significant. Poor dentition is related to use of narcotics and other illicit drugs, limited access to timely dental intervention in the community and poorer oral health preventative behaviours for people who may have had complex lives pre-incarceration. Demand for dental services is extremely high for these cohorts once incarcerated.

Section 54 of the *Crimes (Administration of Sentences) Regulation 2014* provides that dental treatment is to be supplied to inmates in the way and to the extent the Chief Executive, Justice Health and Forensic Mental Health Network, determines.

Demand for public dental services is high not only in NSW prisons but also across the NSW public health system.[439] JH&FMHN adhere to NSW Health policy regarding triage and waitlists.[440] The Centre for Oral Health Strategy (Oral Health Branch of NSW Health) extracts waitlist information from the Information Service for Oral Health (ISOH) on a quarterly basis for review and monitoring.[441] All patients are triaged according to the information they provide themselves, as in community health settings.

Inmates presenting to the health centre with a dental issue will be assessed by a primary health nurse. Standard practice in public prisons is for any immediate intervention to be provided by the primary health nurse in line with dental protocols. The inmate will be instructed to call the Oral Health Information Service (OHIS) line where the operator will ask a series of questions and prioritise the inmate on a dental waitlist for that centre, based on their presenting symptoms.[442] A list of patients is then developed for the next available

438 Information provided by GEO 21 January 2021.

439 Department of Health (NSW), *Priority Oral Health Program (POHP) and Waiting List Management* (Policy Directive, 13 July 2017) 3.

440 Department of Health (NSW), *Priority Oral Health Program (POHP) and Waiting List Management* (Policy Directive, 13 July 2017) 7-12.

441 Information provided by JH&FMHN 2018.

442 Information provided by JH&FMHN 2018.

443 Interviews with inmates 2018

scheduled dental clinic with the OHIS scheduling approximately 10 patients based on prioritisation of need and length of wait. The OHIS utilises the ISOH triaging and prioritisation categories which are standard across NSW public dental services delivered predominantly by Local Health Districts. Inmates can also access this line to enquire about their location on the list.

Each CSNSW centre has its own dental health list, and it is the receiving nurse's responsibility to transfer the inmate to the list and triage appropriately. Health centres also recommend inmates contact the OHIS themselves to advise of their transfer to a new centre, to ensure transfer to the appropriate dental list.[443]

Access to dental services was a significant area of concern identified by inmates during inspection. Many complained of toothache and felt that nurse-initiated pain relief such as ibuprofen or paracetamol was ineffective.[444]

NSW Health policy provides priority levels and recommended clinically appropriate wait times as per Table 17 below.[445]

Table 17: NSW Health Priority Policy

Priority	Adult Triage Criteria	Recommended Maximum Waiting Time
1*	Patients with dental trauma or injury Patients with symptoms of suspected dental origin that may include: • Swelling of the face or neck • Swelling in the mouth • Significant bleeding from the mouth • Difficulty opening jaw and/or swallowing ** Priority 1 patients should be given the earliest possible appointment and concurrently advised to attend an emergency department if they experience an acute deterioration prior to their appointment, or to seek medical attention if otherwise concerned.*	**24 hours**
2	Patients referred from a specialist medical practitioner requiring specific life-saving medical care (e.g. radiotherapy, chemotherapy, organ transplant, heart surgery or urgent assessment for specialist service)	**3 days**
3a**	Patients with pain of suspected dental origin causing disturbedsleep Patients who have had an ulcer for 3 weeks or more ***Priority 3a patients should be given an appointment, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.*	**1 week**

444 Interviews with inmates 2018.

445 Department of Health (NSW), *Priority Oral Health Program (POHP) and Waiting List Management* (Policy Directive, 13 July 2017) 7-9.

446 Information provided by JH&FMHN 2018.

3b^	Patients with pain of suspected dental origin during waking hours ^Priority 3b patients should be given an appointment or waitlisted, and concurrently advised to consider seeking medical attention from a general practitioner if their condition deteriorates, or to re-contact the contact centre to be re-triaged.	**1 month**
3c	Patients who have a denture request involving missing upper front teeth that is required because: • There is no existing denture, **OR** • The existing denture causes pain, **OR** • The existing denture falls out while talking Patients who are pregnant	**3 months**
4	For adult patients who meet one or more of the criteria below: • Has a serious medical condition **AND:** - Takes medication regularly for this medical condition, OR - Sees a doctor regularly for this medical condition, OR - Has been hospitalised in the last 12 months for this medical condition • Has a physical or intellectual disability • Uses a wheelchair or is unable to leave home • Patient has the following living conditions: - Homeless - Boarding house/refuge/rehabilitation facility - Institution/group home - Care facility (hospice/aged care facility) • Arrived as a refugee within the last 12 months • Identifies as an Aboriginal and/or Torres Strait Islander • Referred from a medical practitioner • Referred from an Aged Care Assessment Team (ACAT) • Meets the criteria for a LHD-specific referral pathway	**6 months**
5	For adult patients requesting a check-up with one of the following concerns: • Extractions • Needs fillings or complains of a broken filling • Broken or chipped tooth • Bleeding or sore gums • Loose teeth • Other denture requests including broken plate or clasp • Ulcers for less than three weeks^^ • Crown and bridge • Scale and clean • Clicking/grating in jaw joint • Halitosis (bad breath) ^^*these patients will be given an appointment or placed on a waitlist and at the same time advised to see their medical practitioner for symptomatic management and to assess for medical causes of mouth ulceration.*	**12 months**
6	For patients who request a check-up without any of the above concerns.	**24 months**

Emergency issues are not placed on a waitlist as they are sent to the local hospital for treatment.[446] Over the 2017-2018 period, 40 transfers to hospital occurred because of dental infection, with 18 admissions.[447]

The majority of JH&FMHN health centres have a dental suite/chair with a JH&FMHN dentist or a Visiting Dental Officer (VDO) from the community providing in-reach services. The frequency of services is predominately demand- and-supply-driven, based on dental budget, and the availability of dental officers and dental assistants. A review of oral health staff deployments rosters provided by JH&FMHN confirmed variations in the level of service between centres.[448]

The sample roster shows that larger correctional centres such as Parklea and MRRC correctional centres receive a greater number of dental clinics due to greater demand. Absent from the roster are visits to centres in remote areas such as Broken Hill, and Glen Innes. Inmates in remote areas may access dental services in the community, may be transferred to another centre for review or be reviewed through telehealth.[449]

The inspection team reviewed a sample waitlist of JH&FMHN oral health patients from January 2018-June 2018. Table 18 below shows the number of patients waiting at end of month for JH&FMHN oral health services, between January 2018 and June 2018. As p1 and p2 equate to urgent issues, patients are not placed on a waitlist. This is consistent with NSW Health policy.[450]

Table 18: Number of inmates per JH&FMHN priority class per month during the period January-June 2018

Priority level	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018
1						
2						
3a	27	39	39	33	31	56
3b	303	405	450	483	583	612
3c	71	48	44	50	43	31
4	166	193	224	212	211	234
5	1119	1089	1106	1078	1050	1074
6	271	261	247	249	234	222

Over the 2017-2018 period a total of 8539 patients were seen.[451] This amounts to approximately 62% of all appointments booked, with 6% of appointments (n =876) recorded by the network as 'failed' and 32% (n = 4478) 'cancelled'.[452] The high number of cancelled appointments may be due to inmates being released from custody or transferred to another facility before they are seen. High rates of cancellations contribute to lengthy waitlists.

447 Information provided by JH&FMHN 2018.

448 Information provided by JH&FMHN 2018.

449 Information provided by JH&FMHN.2018.

450 Department of Health (NSW), *Priority Oral Health Program (POHP) and Waiting List Management* (Policy Directive, 13 July 2017) 7-9.

451 Information provided by JH&FMHN 2018.

452 Information provided by JH&FMHN 2018.

453 Information provided by JH&FMHN 2018.

Data showed that over the six months, the number of priority levels 3a, 3b and 4 patients added to the list exceeded the number of patients removed from the list.[453] This is probably due to the number of new receptions into prisons during this period.

Table 19: Average JH&FMHN oral health waitlist figures during the period January-June 2018

JH&FMHN oral health waitlist, Jan - June 2018			
Priority level	**Waiting**	**added**	**removed**
1			
2			
3a	225	349	309
3b	2837	2892	2510
3c	289	129	138
4	1240	542	532
5	6516	1738	1787
6	1484	234	280

3.7.1 Provision of dentures

Provision of dentures can occur within the correctional system under certain circumstances. Dentures can occur for pain reduction, clinical reasons, nutrition maintenance where poor dentition impedes oral intake and health outcomes. It can also contribute to rehabilitation by improving chances of engaging with, or success of, employment programs and opportunities.

Inmates felt there was a long wait to be eligible for dentures.[454] JH&FMHN policy is that dentures may be provided to inmates with a minimum non- parole period of three years, as the preparation includes multiple extractions of one quartile at a time, which must occur over an extended period. If completion of dentures before release is possible, applications outside of the minimum non- parole period may be approved. JH&FMHN report that this occurs approximately once per month.[455]

For the period January 2017 to October 2018, JH&FMHN report:[456]

- 96 sets of dentures issued
- 110 applications were declined or unable to be completed due to patients being released or refusing treatment
- four inmates have received dentures following re-assessment of declined application

JH&FMHN is currently undertaking a dental services policy review which will review the eligibility criteria for dentures.[457]

454 Interviews with inmates 2018.

455 Information provided by JH&FMHN.

456 Information provided by JH&FMHN.

457 Information provided by JH&FMHN.

458 Dental waiting lists are managed on the Titanium electronic oral health record. JH&FMHN are of the view that private providers need to purchase this system to enable the systems to be integrated.

3.7.2 Oral Health service practices at Junee

The oral health triage and prioritisation practice differs for Junee Correctional Centre. A dentist provides clinical services two days per week, which is a relatively high level of dental service compared with JH&FMHN sites inspected. In order to access the dentist at Junee CC, inmates submit a request form directly to the health centre.

Despite, the health service requirements for Junee CC providing for access to the NSW Priority Dental Health Program, in practice Junee CC is not integrated in the state-wide JH&FMHN dental list.[458] The dentist does not have access to the JH&FMHN OHIS, and inmates and staff do not have access to the JH&FMHN oral health line.[459] A separate paper-based Junee CC dental list is maintained manually, and hard copy files must be kept. Therefore, when inmates who are on the JH&FMHN dental list are transferred to Junee CC, they must transfer themselves from the JH&FMHN dental list to the Junee dental list.[460] This disconnection between the two lists leads to some inmates not being on the waitlist and others being placed at the bottom of the dental list, rather than being integrated into the existing list at the appropriate level. To address this, JH&FMHN sends a list once a week of inmates on the dental waiting list who have transferred to privately operated facilities. In practice, the Junee dentist must liaise directly with the JH&FMHN Oral Health Team to ensure patients transferred to Junee from other correctional centres continue to be effectively triaged and managed.[461]

Recommendation 23: Allow Junee CC and other private health providers to access the JH&FMHN dental waitlist.

3.8 Allied health

3.8.1 Physiotherapy

A Physiotherapy Service within JH&FMHN provides musculoskeletal assessment and treatment for musculoskeletal injuries, as well as for post-surgical injury rehabilitation and neurological conditions. The primary physiotherapy clinic is based at an outpatient department within Long Bay Hospital and occurs three to four times per week. Satellite physiotherapy clinics occur once per week at MRRC and Dawn de Loas CC. Monthly clinics occur at John Morony CC, OMMPC, Silverwater Womens CC, and Parklea CC.[462]

Inmates may be transferred from regional or remote centres in order to access these services. Telehealth may also be utilised for physiotherapy triage and assessment.[463] Some inmates requiring further specialist physiotherapy are referred externally and followed up to ensure continuum of care.[464]

3.8.2 Medical Imaging

Urgent medical imaging for inmates at regionally located correctional centres must occur at the local hospital. Non-urgent medical imaging is available to inmates in certain correctional centres, in the form of digital radiography. This is facilitated by visiting radiographers on an in-reach basis and images are transmitted to a radiologist for reporting (usually at Prince of Wales hospital). JH&FMHN delivers radiography

459 Interviews with staff 2018.

460 Interviews with staff 2018.

461 Information provided by GEO 21 January 2021

462 Information provided by JH&FMHN.

463 Justice Health and Forensic Mental Health Network, *Year in Review 2016-2017* (Department of Health (NSW), December 2017) 17.

464 Justice Health and Forensic Mental Health Network, *Clinical Services Provided by JH&FMHN* (Policy 1.080, 4 November 2014) 4.

465 Information provided by JH&FMHN.

services at the centres below on the following basis:[465]

- Long Bay Hospital - twice per week (ultrasound also provided three times per month).
- Metropolitan Remand and Reception Centre/ Silverwater Women's CC - twice per week
- South Coast CC – once per fortnight
- Goulburn – once per week, by a radiographer from Goulburn Hospital
- Wellington – once per fortnight by a radiographer from Orange Base or Wellington Hospital
- Mid North Coast CC - ad hoc

In the period 2017-2018, 75 per cent of medical imaging appointments occurred within JH&FMHN health centres (n = 2450) with the remainder occurring in LHDs as booked by the medical appointments unit.[466]

Medical imaging in-reach services are available once per week at Junee CC or on-call as required. As part of the prison expansion project, a larger radiology room has now been commissioned with new radiology equipment including an OPG.[467] St Vincents Health Network provides medical imaging in-reach services at Parklea CC five days per week.

3.8.3 Podiatry

In the community, podiatry services are usually provided in a community health centre or by a private provider. Some services may receive the MBS rebate if the person is on a chronic health plan established by a GP. In custody, podiatry services are predominantly provided to patients with chronic diseases such as diabetes. The podiatry service is not available to all inmates.

JH&FMHN holds a current Service Level Agreement with a private provider who services LBH and the Forensic Hospital on an as-needs basis.[468] Beyond this, podiatry services may be accessed as a private health service at the inmate's own cost according to CSNSW's private health policy. St Vincents Health Network provides a podiatry service at Parklea CC.

3.8.4 Optometry

Optometry services are provided in the community via a health centre or private provider. Optical treatment is supplied to inmates in the way and to the extent the Chief Executive of JH&FMHN determines.[469] In practice, the frequency of adult optometry services in NSW correctional centres is dependent on the size and presenting need of a correctional centre.[470] Optometry waiting lists are regularly reviewed and triaged taking into account diabetes, hypertension, and sudden vision loss.[471] Clinics are scheduled according to need.[472] At the time of inspection optometry clinics operated across 30 health centres.[473] Larger metropolitan centres such as MRRC, Long Bay Correctional Complex and Parklea CC have more frequent clinics. Rural sites such as Goulburn or South Coast Correctional centres hold bi-monthly clinics as these centres have

466 Information provided by JH&FMHN.

467 Information provided by GEO 21 January 2021

468 Information provided by JH&FMHN.

469 Crimes (Administration of Sentences) Regulation 2014 clause 54.

470 Information provided by JH&FMHN 2018.

471 JH&FMHN policy 1.303.

472 Information provided by JH&FMHN 2018.

473 Information provided by JH&FMHN 2018.

474 For example Oberon and St Helliers CCs require two monthly clinics.

greater waitlist times. Allocation of clinics to smaller rural sites will occur based on need and will be less frequent.[474] If a centre is not serviced by optometrist clinics, an inmate may be transferred to another centre where the service is provided.

JH&FMHN policy states that inmates in custody for less than six months will be provided optometry services in urgent situations only, where their health or well-being may be significantly compromised.[475]

CSNSW policy states:

> *JH&FMHN provides basic non-prescription reading glasses (magnifying glasses) free of charge to inmates to provide short-term relief. If the non-prescription reading glasses are insufficient or the inmate has a previous history, medical requirement or problem/trauma to their eye, they will be assessed by an optometrist for prescription requirements*[476]

The non-prescription spectacle program allows inmates to access reading glasses without having to see an optometrist, and has reduced the optometry waiting list and improved access for patients requiring optometry review.[477] However, some inmates believed that access to non-prescription reading glasses was not always sufficient and did not always improve vision.[478] Adequate optometry services are important in prisons as glasses affect inmates' ability to interact effectively with the justice system (e.g. reading legal papers), perform work safely, and participate in programs and education.[479]

3.9 Chronic and complex health

Early detection and management of chronic health conditions in custody is important for limiting the progress of these conditions post release (or deterioration during incarceration). Failure to manage these conditions can lead to pressure on community health services and emergency departments to manage these conditions at a more acute stage.[480] Inmates in custody may have greater access to chronic health monitoring than in the community due to their proximity to the health service.

A chronic disease screen may occur as a result of the reception screening assessment and, may lead to a chronic care clinical pathway plan.[481] Inmates identified as having chronic health needs upon reception receive regular chronic heath assessments. Chronic care screenings may be more difficult to manage when an inmate is on remand due to movements between centres impacting the regularity of screening.

JHFMHN noted that 5% of the 2015 *Network Patient Health Survey* (NPHS) respondents reported diabetes.[482] JH&FMHN have placed a significant focus on the management of inmates with diabetes. This a particular challenge given the needle free environment. Patients usually self- administer in the community, however in custodial facilities all insulin injections must be administered in the health centre.

Health centres facilitate blood glucose monitoring and insulin injections for diabetics. CSNSW works in consultation with JH&FMHN to provide diabetic inmates with services and facilities required for their illness. It is the responsibility of JH&FMHN to advise the governor of a correctional centre of the names of any

475 JH&FMHN Policy 1.303 p3

476 Corrective Services NSW, Inmate Health Needs (Custodial Operations Policy and Procedures, Policy 6.3, version 1.3, 3 June 2020) 7 at pt 4.3.

477 Information provided by JH&FMHN 2018.

478 Interviews with inmates 2018.

479 Interviews with staff and inmates 2018.

480 2015 *Network Patient Health Survey* p15.

481 Justice Health and Forensic Mental Health Network, *Health Assessments in Male and Female Adult Correctional Centres and Police Cells* (Policy 1.225, 12 July 2017) 5,6.

482 2015 *Network Patient Health Survey* p15.

483 Corrective Services NSW, Inmate Health Needs (Custodial Operations Policy and Procedures, Policy 6.3, Version 1) 6.

inmates with a diabetic condition. It is the responsibility of the Governor to ensure diabetics have access to health centres, access to glucometers or other testing equipment, have access to appropriate food and adequate supplies between meals or during transport.[483]Access to the clinic for glucose blood sugar level monitoring and accessing injectable insulin per medical officer prescription was observed in all clinics during the inspection. While sometimes the administration of insulin occurred in areas with limited privacy, the inspection team observed an appropriate balance of self-administration of glucose monitoring and insulin administration with appropriate clinical oversight given the nature of the correctional environment.

Haemodialysis is provided at Long Bay Hospital for inmates in the metropolitan area. Two machines are available, and inmates attend on an outpatient basis. Staff at Long Bay Hospital reported the machines were used six days per week by eight inmates. It was suggested that use of the dialysis machines was at capacity, and there are times when demand for haemodialysis exceeds supply and availability of machines. However, JH&FMHN advise that 'the network has capacity to meet demand'.[484] Although JH&FMHN policy provides for inmates to be transferred to the Local Health District for dialysis three times per week, JH&FMHN advise it is managed within LBH and 'only in exceptional circumstances are patients sent to Prince of Wales Hospital'.[485] In 2018 there were 1128 occasions of service for dialysis.[486]

An integrated care service is available to inmates with chronic health issues upon release from custody and aims to achieve continuity of care to community health services. This is an initiative within JH&FMHN, with LHDs and communities in Western NSW identified as priority areas.

JH&FMHN policy requires metabolic monitoring of inmates on any type of antipsychotic drug, including Mertazapine, a common anti-depressant medication.[487] Given the estimated rate of antipsychotic prescription in NSW correctional centres, the need for metabolic monitoring for chronic disease of all inmates receiving antipsychotic medication has placed significant demands on health centres to monitor, conduct monthly weight, waist and hip measurements, six-monthly blood sugar, cholesterol, and kidney function screening, and annual electrocardiograms.

There are significant risks with anti-psychotic medications that require ongoing monitoring. There are reports of some of these being tradeable and used as currency within prisons. It is appropriate that the use of medication is reviewed for clinical appropriateness and to prevent potential for misuse in a custodial setting. The high use of Seroquel, Gabapentin, and Quetiapine is one example of the need to move towards appropriate and limited prescribing of these and similar medications in the correctional environment.

GEO's 3 Year Health Services Action Plan includes; 'Ensure the development and implementation of health promotion strategies/initiatives to address or mitigate risks associated with chronic diseases and/or obesity'.[488] Junee CC employs a dedicated metabolic monitoring nurse to perform screenings and maintain the significant associated records.[489] The nurse reported that approximately 400 of the 800 inmate population were eligible for metabolic monitoring, and frequent triaging was required in order to manage the risk of inmates deteriorating.[490] A metabolic monitoring e-form is now available in JHeHs to capture data for a 12 month period.

484 Information provided by JH&FMHN 2018.

485 Justice Health and Forensic Mental Health Network, *Clinical Services Provided by JH&FMHN* (Policy 1.080, 4 November 2014) p 6.

486 Information provided by JH&FMHN 2019.

487 'Psychotropic Medications – Guidelines for prescribing and monitoring use within custodial and forensic mental health settings 2017', and the associated NSW Ministry of Health Information Bulletin, Metabolic Monitoring, New Mental Health Clinical Documentation Module.

488 Information provided by GEO 21 January 2021

489 Interviews with staff 2018.

490 Interviews with staff 2018.

491 CSNSW, Male & Female CSNSW generic weekly grocery buy-up list, December 2018 p1.

3.10 Environmental health and hygiene

Environmental health and hygiene in prisons is important for stopping the spread of bacterial infection and associated illness. Rule 18 of the *Mandela Rules* states:

1. *Prisoners shall be required to keep their persons clean, and to this end they shall be provided with water and with such toilet articles as are necessary for health and cleanliness.*
2. *In order that prisoners may maintain a good appearance compatible with their self-respect, facilities shall be provided for the proper care of the hair and beard, and men shall be able to shave regularly*

A reception pack provided to inmates new to custody contains a small toothpaste, soap, razor, and a toothbrush. Additional items including deodorant, shower gel and shampoo are not supplied and must be purchased by inmates with their own money through the 'buy-ups' system.[491] Some inmates expressed concern that deodorant was not made available in reception packs.[492] They noted that temperatures in regional NSW can reach high 30s, that air-conditioning is not available, and that 'buy-ups' are only available on a two week cycle. This means if an inmate is received into custody immediately after buy-ups they cannot purchase deodorant, shampoo or toothpaste for two weeks. Inmates who do not receive financial support from family or friends in the community are also at a disadvantage. There is further disadvantage if inmates are in remand centres with limited employment opportunities. Finances should not limit an inmate's ability to maintain their personal hygiene and dignity, especially when living in such close quarters with others.

Availability of barber facilities is an important issue for inmates. In some centres barber facilities are located within the accommodation wings but not utilised due to broken equipment or staff not being available to supervise.[493] Access to barbers' facilities, clippers, and cleaning products is important for maintaining personal hygiene and appearance. Providing barber courses and qualifications to inmates also provides useful employment skills. It also mitigates against the potential risk of transmitting Hepatitis B and C, which may increase if untrained people are providing the service. The inspection team observed an inmate barber cutting hair, under the supervision of several officers, at Tamworth CC. The inmate had not undertaken a course or been provided with adequate cleaning or hygiene products.[494] This was despite the centre delivering a barber course.

CSNSW should provide inmates with clean hair cutting equipment as required by the CSNSW policy. This is to stop the spread of BBVs and other transmittable diseases. It also helps prevent outbreaks of lice and scabies within the prison environment, thereby assisting with maintaining good environmental health. This is important from a hygiene and public health perspective. Fincol is a hospital-grade caustic disinfectant approved for inmate use by CSNSW. It is available in all accommodation areas in diluted form in a locked dispenser. The CSNSW Custodial Operations Policies and Procedures (COPP) states that fincol should be used for, but not limited to, cleaning blood and bodily fluids spills; cells, toilets and shower areas; barbering and hairdressing equipment; injecting drug use equipment and tattooing equipment; and other situations which may prevent the spread of blood-borne infections. CSNSW policy states that fincol must be available to inmates during all out of cell hours, and that inmates are permitted to take one cup or container of fincol to their cell after lock-in. [495]

492 Interviews with inmates 2018.

493 Interviews with inmates and staff 2018.

494 Interviews with staff 2018.

495 Corrective Services NSW, Infectious and Communicable Diseases (Custodial Operations Policy and Procedures, Policy 6.5, Version 1) 8.

496 NSW Health, Justice Health & Forensic Mental Health Network, *Access to Local Public Health Services*, policy 1.252 issued 16 December 2013, p. 1.

Centres inspected were generally found to be of an acceptable standard of cleanliness. In a few isolated cases where this was not the case, this was raised directly with the centre. Ventilation was found to be an issue in centres with older infrastructure such as Tamworth and Cessnock Correctional Centres. Sharing cells with two or more inmates makes the maintenance of hygiene particularly challenging. It is crucial that adequate cleaning equipment is made available for inmates; even more so during a pandemic.

A further aspect of environmental health is adequate access to ovals for exercise and exposure to sunlight. Where centres had adequate custodial staffing, this was generally being achieved, although this is more difficult for inmates requiring protection from other inmates.

Recommendation 24: CSNSW provide necessary hygiene items to all inmates.

3.11 Secondary and specialist health services

Non-emergency specialist outpatient appointments are available to inmates at the Prince of Wales Hospital, Randwick. If an inmate is in need of a specialist appointment, health centre staff will generate a referral on PAS and provide a signed copy of the referral to the JH&FMHN medical appointments unit located on the Long Bay Correctional Complex.[496] For the period 2017-2018, there were 3626 external medical appointments for male patients booked by the JH&FMHN medical appointments unit. 76% of these (n=2755) occurred at Prince of Wales.[497] Local hospitals in the metropolitan and regional areas are to be utilised for diagnostic medical imaging and emergency care only.[498] This means that inmates in regional locations who require specialist outpatient services must transfer to Long Bay CC ahead of their specialist appointment at Prince of Wales Hospital.

Inmates who are transferred to Long Bay CC may spend weeks or months at Long Bay CC before they are able to be transferred back to their centre of classification.[499] This interrupts an inmate's ability to perform work, undertake education courses, or complete programs to address their re-offending behaviour. It can also interfere with an inmate's ability to maintain contact with their families. Consequently, many inmates cancel their specialist appointments to avoid being transferred to Long Bay CC. This can result in a failure to diagnose or treat serious or chronic health issues that may become medical emergencies. It is acknowledged that dependant on location, some centres will utilise outpatient services at their local hospital for local specialist review.

3.12 Tertiary care

Inmates may require access to higher levels of care outside their correctional centre, involving supervision and escorts. This may occur in a number of contexts:

- Inmates at a non-metropolitan centre requiring escort to a local hospital for diagnostic medical imaging, or for an emergency
- Inmates from a non-metropolitan centre requiring escort to the Long Bay Correctional Complex, Malabar where they are accommodated at LBH2 or MSPC while they wait for their scheduled specialist appointment at the Prince of Wales Hospital, Randwick[500]
- Inmates at a metropolitan centre requiring escort to Prince of Wales Hospital, Randwick (PoWH) or

497 Information provided by JH&FMHN 2018.

498 Information provided by JH&FMHN 2018.

499 Inmates are accommodated in correctional centres appropriate to their security classification. The inmate's designated centre is known as the 'centre of classification'.

500 Long Bay Hospital 2 is not a hospital as the nomenclature suggests, but rather a correctional centre on the Long Bay Correctional Complex housing a mix of remand inmates and inmates transferred from regional areas awaiting specialist appointments.

501 Interviews with staff 2018.

another metropolitan hospital for a scheduled medical appointment

- Inmates at a metropolitan centre requiring emergency treatment at a metropolitan hospital

3.12.1 Local hospitals

Where JH&FMHN staff recommend emergency transfer to a local hospital, it is the responsibility of CSNSW to ensure that this occurs. CSNSW policy requires that a valid movement order is raised before a patient is transferred to hospital. This requires JH&FMHN staff to liaise with the centre's officer in charge to ensure that this occurs within a timeframe appropriate to the patient's clinical need. Delays in transporting inmates may sometimes occur due to CSNSW operational issues.[501] At the time of inspection, a draft MOU was under development between NSW Health (including NSW Ambulance and JH&FMHN) and CSNSW to promote partnership and understanding around hospital transfers and admissions. The MOU will include protocols on information sharing, transport, and define the roles and responsibilities of each agency. Initiatives such as this improve timely access to appropriate care and are supported by the Inspector.

If a patient is admitted to a public hospital it is the responsibility of the referring centre's NUM or delegate to contact the hospital ward on a daily basis to enquire as to the patient's condition.[502]JH&FMHN staff stressed the importance of strong relationships between regional correctional centres and local hospitals. Some JH&FMHN staff reported that it was difficult to obtain information about at inmate held at a local hospital as an inpatient without attending in person, as LHD staff were righty concerned with patient confidentiality. The inspection team observed good practice at the local level to work around these challenges. For example, Tamworth CC established an interagency working group to optimise patient transfer and communication between the health centre, custodial staff and the hospital. Similarly, the NUM at John Morony CC attended the hospital in person to establish information about an inmates' clinical progress.

Although NSW Health and JH&FMHN have agreed to identify and implement processes that allow for continuity of care and appropriate communication between correctional centres and LHDs while maintaining patient confidentiality, at a local level it has not been fully operationalised. The eventual use of an integrated electronic health information system across JH&FMHN and local health districts may alleviate the need for health centre staff to travel to local hospitals, and save time spent on security checks.

3.12.2 Prince of Wales Hospital, Randwick

Prince of Wales Hospital, Randwick is part of South Eastern Sydney LHD and facilitates the majority of outpatient specialist appointments for CSNSW inmates. It also takes critically unwell patients requiring constant clinical monitoring or intensive care. Inmates attending hospital in an emergency or for a scheduled appointment always remain under guard.

The hospital also has a secure annex which is a gazetted correctional facility comprising seven beds across three rooms. The annex is staffed by CSNSW custodial staff and NSW Health staff and allows secure inpatient treatment for stable pre and post –operative illnesses and palliative care. Redevelopment of the annex is currently underway to increase the number of inpatient beds.

3.12.3 Long Bay Hospital 1

Long Bay Hospital 1 is a gazetted correctional facility on the Long Bay Correctional Complex, Malabar. It comprises a 15-bed aged care and rehabilitation unit (ACRU), 29 bed medical sub-acute unit, and a 40-

502 NSW Health, Justice Health & Forensic Mental Health Network, *Access to Local Public Health Services*, policy issued 16 December 2013, p. 3.
503 Justice Health & Forensic Mental Health Network, *Long Bay Hospital - Admission Policy* (draft) p 4.

bed mental health unit. A GP works at LBH1 from Monday to Friday during office hours with queries outside these hours directed to ROAMS.

Decisions to transfer inmates to LBH result from a discussion between a referring medical officer (usually a NUM) and an accepting medical officer. The accepting medical officer must ensure the referral is completed, determine immediate needs, determine the clinical priorities and urgency of the referral, and make the final decision for admission. If a referral is refused, reasons for refusal must be stated. The Nurse Manager Operations – access and demand is advised of the decision.[503]

The Medical Subacute Unit (MSU) provides inpatient pre and post-operative care, medical observations, haemodialysis, isolation assessment and treatment for communicable disease, and convalescence to patients of the NSW correctional system. It is not an acute hospital unit. The unit accommodates:

- inmates whose health care needs cannot be met in a normal correctional environment or ambulatory health centre setting
- inmates with chronic conditions at risk of an adverse clinical event
- patients requiring care while receiving chemotherapy or radiotherapy
- inmates requiring multiple investigations at Prince of Wales Hospital. [504]

Referrals to the MSU are accepted from NSW correctional centres, police cell complexes, or from LHDs treating NSW inmates. Referrals occur according to the NSW Health interfacility transfer policy. At all correctional centres inspected, health centre staff spoke of the perceived difficulty of having inmates admitted to LBH. On average the MSU accepts one to two patients per day, or about 50 per month. Most patients are admitted within 24 hours. Accordingly, there is no waitlist as such.[505] Admissions may be refused if the patient requires frequent allied health rehabilitation, as this is only available once per week in the unit.

3.12.4 External medical appointments

External medical appointments impact CSNSW budget, custodial staff, and inmates. Custodial staff reported the significant impact of medical escorts on CSNSW from a transport, human resources and security perspective. In all of the above scenarios, staff must be reallocated from custodial supervision or engaged in overtime shifts, to escort inmates to local hospitals or to the Long Bay Correctional Complex. Admission to tertiary facilities requires full-time custodial supervision.

Work of an unpredictable nature is not listed on correctional centre rosters. Un-rostered work is mainly escorting prisoners to hospital and supervising them while in hospital. Because it is not rostered, permanent staff are not employed for those tasks. Un-rostered work is performed on overtime (70%) or by casuals (30%).[506]

CSNSW advise that hospital escorts are no longer as unpredictable. In the larger prisons, volumes have increased and consistency in the pattern of escorts is well established. (see Figure 9 below)[507]

504 Justice Health & Forensic Mental Health Network, *Admission and Assessment: Medical Subacute Unit, Long Bay Hospital*, policy issued 22 July 2014, pp. 2-3.

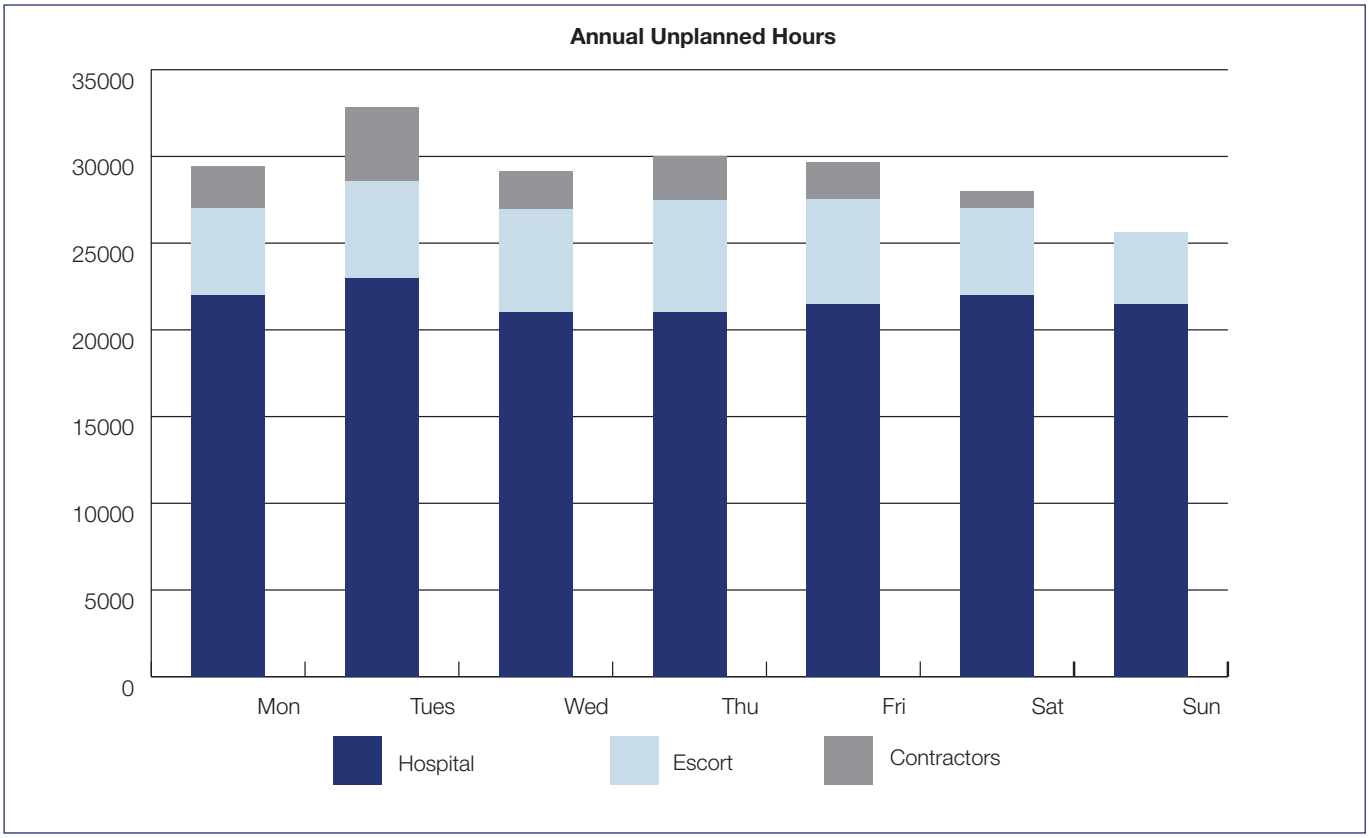
505 Interviews with staff 2018.

506 Information provided by CSNSW August 2020

507 Information provided by CSNSW August 2020.

508 Information provided by CSWSW 2020.

Figure 9: Annual Unplanned Hours, by Days of the Week, During the Financial Year 2017-18



In 2017/18 Corrective Services NSW (CSNSW) serviced around 3,358 scheduled medical escorts and 10,210 unscheduled medical escorts in the metropolitan area. The redeployment of centre staff to perform scheduled and unscheduled medical escorts frequently results in partial correctional centre lock ins. Centres facilitate escorts by utilising casual correctional officers; staff on overtime and redeploying centre staff. These activities are estimated to cost CSNSW around $18.2M per annum.[508]

Data from February and March 2019 revealed 7,911 movements associated with unscheduled escorts over the period, with a total cost of $3,710,032.[509] At that time CSNSW did not record reasons for unscheduled escorts.[510] However, unscheduled escorts are generally in response to an emergency situation and are more likely to result in inmates being locked in their cells and having fewer hours out of their cells.

There is no suggestion that JH&FMHN are sending inmates to Emergency Departments unnecessarily. Inmates are presenting with more chronic and complex illnesses and co-morbidities because of the increasing numbers of Aboriginal inmates and aged inmates. JH&FMHN advise that although inmates sent to Emergency Departments make up about .18% of total Emergency Department presentations, there is a 30% chance of being admitted. This is comparable and sometimes higher than the admission rates for members of the public.[511]

CSNSW recognised the challenges around medical escorts and in response established a Medical Escorts Pilot for scheduled medical escorts in Metropolitan Sydney based at the Long Bay Correctional Complex.

509 Information provided by CSNSW 2019.

510 Information provided by CSNSW 2019.

511 Information provided by JH&FMHN January 2020.

512 Information provided by JH&FMHN 2018. This is for appointments at Prince of Wales only. It is the responsibility of individual correctional centres in regional areas to keep information about cancellations and reasons.

The first two full months of data illustrated the scale of the resources required to ensure inmate's access to care:

Table 20: CSNSW Scheduled Medical Escorts for February-March 2019

Month	Scheduled	Completed	Cost
February	516	343 (66%)	$2,232,397.48
March	520	318 (61%)	$2,290,671.90

Data was also obtained about the reasons for cancellations of scheduled medical appointments during this period. CSNSW recorded the following reasons for cancellations of scheduled appointments.

Table 21: Reasons for Cancellations of Scheduled Medical Appointments during February-March 2019

Reason	Frequency	As a Percentage of all reasons
Patient at non-LBC centre cancels prior to transfer	130	24.21%
Patient released from custody	83	15.46%
Cancelled by health care provider	55	10.24%
Patient was at another jail	43	8.01%
Cancelled by triage nurse as doctor says appointment no longer required	42	7.82%
Patient housed at LBC cancels appointment	41	7.64%
Patient not transferred out due to a shortage of escorting officers	30	5.59%
Due to corrective services	22	4.10%
Escort team have to attend a more urgent issue at PoW annex	17	3.17%
Patient at court	15	2.79%
Preceding appointment took longer than planned or more urgent appointment took place	12	2.23%
Cancelled by MAU - appointment made in error or rescheduled	10	1.86%
Centre closure e.g. due to industrial action	10	1.86%
Cancelled by Prince of Wales Annex NUM	10	1.86%
Cancelled by MAU, no longer required i.e. patient may have already had procedure	5	0.93%
Patient didn't answer page or sick	4	0.74%
Extreme high security	4	0.74%
Specialist cancelled clinic	3	0.56%
Patient transferred to another centre without MAU being informed	1	0.19%

The data is consistent with the JH&FMHN 2017 data for cancellations shown at Table 22 below.[512]

513 Information provided by CSNSW 4 February 2021.

Table 22: Reasons for Cancellation of External Medical Appointments in 2017

Reason	Frequency
Cancelled by patient prior to transfer to LBCC	478
Cancelled by health provider	274
Cancelled by patient on LBCC	254
Medical escort team cancels	230
Patient released from custody	224
Urgent appointment takes priority	163
Cancelled by triage nurse (psych)	159
A1 Other escort took longer than planned	91
Patient at court	61
Patient in another centre at the time	59
Cancelled by specialist	45
Appointment made in error	33
Not transferred centre closure	32
Cancelled by DCS	27
No longer required	24
Did not answer page or other reason	16
Annex escort	13
Extra high risk	11
Patient transferred	6
Patient unwell	4
MRD appointments staff cancelled	3
Total	**2207**

It suggested that in some cases, the CSNSW medical escorts team cancels, or the scheduled medical escort did not occur. This demonstrated the need for dedicated resources to ensure access to appropriate care.

A MEU Pilot commenced in 2018 to facilitate scheduled medical escorts in the metropolitan region (Monday to Friday). The pilot comprised nine teams of two staff based at LBCC, nine teams of two based out of SWCC, and an administrative clerk. This meant custodial staff were not drawn upon to conduct scheduled medical escorts in the Sydney metropolitan region. It was hoped the pilot would improve efficiencies, enhance bed flow, and limit the length of time inmates spend at LBH2 waiting for their appointment. The pilot allowed CSNSW to capture data regarding the number of medical escorts, both scheduled and unscheduled.[513]

From 11 June 2019 to 17 November 2019 the MEU:

- Facilitated over 2,700 medical escorts
- Significantly reduced the prevalence of lock - ins increasing inmate time out of cell and engagement in rehabilitation activities linked to the Premiers Priority of reducing recidivism by 5% by 2023
- Reduced average hourly escort costs
- Increased the number of medical escorts delivered reducing inmate wait times to access specialist medical treatment
- Delivered improved service delivery standards
- Enabled the capture and monitoring of escort related expenditure.
- Improved local relationships with Justice Health and Forensic Mental Health Network (JH&FMHN) and NSW Health.

Forming a central CSNSW point of contact for medical escorts and establishing monthly meetings between key stakeholders also enabled the timely rectification of issues and forward planning. Moreover, it has seen a reduction in medical appointment cancellations caused by CSNSW, which in turn has increased access to specialist health care which mitigates the risk of emergency hospital admissions.

The data in relation to external medical appointments also showed that patient cancellations made up around one third of all cancellations. In 2017, 254 appointments were cancelled by patients at the LBCC and 478 appointments were cancelled before the patient was transferred to LBCC. High rates of cancellations including before inmates are transferred to the LBCC suggests that inmates do not want to be transferred to LBCC. This is concerning as inmates who cancel specialist appointments for chronic illnesses may ultimately become acutely unwell and require emergency inpatient treatment.

It is not uncommon for inmates accommodated in regional centres to spend weeks and sometimes months at LBCC to attend a specialist medical appointment. Transfer to LBCC reduces the inmates' access to rehabilitative and employment training opportunities, family, local community, and the ability to reside in a centre of appropriate lower level security classification, as LBCC is a maximum security correctional centre. Inmates may therefore cancel their appointment as they do not want to be transferred from their centre of classification. The 2015 ICS report, *Full House*, identified that over half of cancellations were made by inmates. [514]

515 Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population' (Report, April 2015) 57, pt 5.56.

515 Information provided by CSNSW September 2020.

This suggests the need for a 'hub and spoke' model with dedicated Medical Escorts Units located at regional centres such as the Cessnock Correctional Complex providing escorts to hospitals within the LHDs. This is important considering the significant inmate populations in Cessnock (1788), Grafton (Clarence)/Kempsey (2802), Wellington / Macquarie (1142) and Nowra (980).[515]

A hub and spoke model may have a range of benefits including: improving timely access to health care for inmates; allowing inmates to maintain their bed in a correctional centre and access to rehabilitative programs and family; reducing movements between correctional centres (regional correctional centres to LBCC); and relieving some of the demand upon Prince of Wales Hospital and LBH, which in turn will reduce wait times.

Next steps should consider an appropriately resourced and funded approach to scheduled appointments in metropolitan and regional hubs, and unscheduled escorts across the state. As the MEU pilot phase is now complete, a business case is currently being prepared with an outcome expected within the first quarter of 2021.[516]

Recommendation 25: CSNSW implement an appropriately planned and resourced Medical Escorts Unit to service key regional and metropolitan hubs

516 Information provided by CSNSW 4 February 2021.

517 World Health Organisation, *Prisons and health*, 2014, p2

4. Access to health services

The World Health Organisation identifies that

> *it is not […] easy to provide health care in prisons which by their nature are designed for safe custody and provided with regimes that have necessarily developed around questions of security*.[517]

This section will discuss how inmates access health services in correctional centres and the systems currently supporting this. Constraints upon access identified during inspections will be outlined. These include physical infrastructure, relationships between custodial and health providers, workforce recruitment, and supply versus demand.

Access to higher levels of care will then be discussed. This includes aged care, and the use of telehealth. The role of clinical information systems in improving access to health services and patient flow is also addressed.

4.1 Accessing health services within correctional centres

4.1.1 Reception

The reception and intake screening process occurs upon an inmate's entry to prison. It is a critical time for gathering information to assess risk and inform the management of inmates.[518] Reception screening is particularly important for determining health concerns and their ongoing management.[519]

When an inmate is newly received into police cells and/or a reception prison, they will be interviewed by a custodial officer who completes an *Inmate identification and observation* (IIO) form including questions around health, mental health, substance use history, and risk of self-harm or suicide. [520] CSNSW policy requires a copy of the IIO to be provided to the health provider immediately.[521]

In most cases observed by the inspection team, this process ran smoothly. However, despite clear policy, the inspection team observed one instance where information obtained by custodial staff during the IIO process about an inmate's custodial and mental health history was not conveyed to the relevant health provider prior to the commencement of the Reception Screening Assessment (RSA). This resulted in confusion between staff and frustration from the inmate. It is a risk to the provision of adequate care if information is not conveyed between agencies according to policy.

The existing JH&FMHN *Communicating Private Correctional Health Centre Operators* policy provides some guidance to JH&FMHN staff on the degree of information that may be shared with private health providers.[522] However this should also include information provided by private providers to JH&FMHN. This would assist with information transparency and improve patient care. *JH&FMHN Privacy Manual for Health Information* covers CSNSW but needs to be expanded to include private operators.

Recommendation 26: JH&FMHN, private health providers and CSNSW work together to ensure information sharing occurs in accordance with policy

518 COPP 4.1 p10

519 RACGP, *Standards for health services in Australian prisons*, 2011, p11

520 COPP 1.1. An Immediate Support Plan (ISP) and a Mandatory Notification Form (MNF) must be completed if an inmate is identified as being at risk of self-harm.

521 COPP 1.1 p 13

522 Information provided by JH&FMHN, 21 February 2021.

523 Justice Health and Forensic Mental Health Network, *Health Assessments in Male and Female Adult Correctional Centres and Police Cells* (Policy 1.225, 12 July 2017) p 4.; Information provided by GEO 21 January 2021.

Following completion of the IIO, a RSA will be undertaken by a JH&FMHN RN or the relevant private provider RN in order to identify any primary health, mental health, drug and alcohol or population health issues requiring treatment.[523]The assessment should occur within 24 hours, or as soon as possible thereafter.[524] In some cases JH&FMHN cannot complete an RSA if an inmate is received in the evening and staff are not present. In such cases, CSNSW are required to notify the after-hours nurse manager and the RSA will be undertaken at the next available opportunity.

If a health need is identified in the RSA, alerts for health conditions are added to the Justice Health Electronic Health System (JHeHS), Health Problem Notification Forms (HPNFs) are generated and referred to CSNSW, referrals and appointments are made with appropriate health practitioners, and a Request of Information (ROI) faxed to the inmate's community health care provider.[525] This is especially important for establishing information about prescription medication. The inspection team heard from some health centre staff that receiving replies to ROIs can take time. It is acknowledged that this is out of the control of health centres. The utilisation of the My Health Record by inmates may be able to streamline this process.

Prior to being deemed suitable for undertaking RSAs, JH&FMHN and other health provider nurses must have knowledge of drug and alcohol, population health, and mental health assessment and management.[526] They must also complete specific reception screening training including face-to-face and online components.[527] A minimum of five receptions must be completed under the guidance of a preceptor or clinical nurse educator. JH&FMHN report that this training process covers guidelines and requirements for all custodial presentations.[528]

All new GEO staff are required to complete the Orientation Training (OT) package which specifically details requirements for reception screening of inmates. Following completion of the OT package, staff are assessed by the HSM and identified as competent. New staff also receive an in-service of the JH&FMHN Reception Screening Assessment Training Handbook (Adults).[529]

The inspection team observed and confirmed with discussions, that some staff felt they had not been provided with the full orientation or skill set required to deliver RSA's as competently as they desired, and thought was required.[530]

It is important to handle the RSA sensitively, especially regarding discussion of mental health and self-harm. This is particularly important for Aboriginal inmates and inmates from culturally diverse backgrounds,

524 Justice Health and Forensic Mental Health Network, *Health Assessments in Male and Female Adult Correctional Centres and Police Cells* (Policy 1.225, 12 July 2017) 4.

525 Justice Health and Forensic Mental Health Network, *Health Assessments in Male and Female Adult Correctional Centres* (Policy 1.225, 5 May 2015) 4.

526 Justice Health and Forensic Mental Health Network, *Health Assessments in Male and Female Adult Correctional Centres* (Policy 1.225, 5 May 2015) 5.

527 Justice Health and Forensic Mental Health Network, 'Response to Request for Information: Inspector of Custodial Services (NSW) Inspection into the Provision of Health Services' (8 January 2019) item 27; Justice Health and Forensic Mental Health Network, *Health Assessments in Male and Female Adult Correctional Centres* (Policy 1.225, 5 May 2015) 5.

528 Justice Health and Forensic Mental Health Network, 'Response to Request for Information: Inspector of Custodial Services (NSW) Inspection into the Provision of Health Services' (8 January 2019) item 27.

529 Information provided by GEO 21 January 2021.

530 Interviews with staff 2018.

531 Stephane Shepherd, 'Aboriginal Prisoners with Cognitive Impairment: Is this the Highest Risk Group?' (Research Paper No 536, Trends and Issues in Crime and Justice, Australian Institute of Criminology, October 2017) 2.

as culture influences ways of understanding and expressing health need.[531] Communication and cultural responsivity during the RSA may also influence an inmate's future engagement with the health service. Optimising access to health services in this way is particularly important given the overrepresentation of Aboriginal people in custody and in the overall burden of chronic disease.[532]

JH&FMHN commenced a reception redesign project commenced at MRRC in late 2020. It is expected recommendations will include training of staff in reception assessments.[533]

Recommendation 27: JH&FMHN and private health providers delivering reception assessments provide education and training programs and ensure staff are trained to conduct Reception Screening Assessments, initial competency is confirmed, ongoing competency maintained, and ensure staff are afforded opportunities to address knowledge gaps.

4.1.1.1 Inter-facility transfers

Where patients are being moved for operational, custodial and classification reasons, patients are assessed to ensure all health care needs are met. Policy requires that clinical needs of patients are considered and managed appropriately before during and after transfer.[534] A *Transfer In and Out Form* is to be completed by health staff for all patients transferred in and out of a correctional facility.[535] The Integrated Care Service (ICS) is responsible for ensuring continuity of care occurs for ICS-enrolled patients. Whenever there is doubt about the appropriateness of a transfer this can be escalated within or to JH&FMHN. Patient medical records and medication charts travel with the inmate.

All patients must be assessed by an RN/EN at the receiving correctional centre within 24 hours. This includes reviewing the inmate's health record and past or upcoming appointments. This should be crosschecked with the transfer in and out form.[536]

Where possible, the inspection team viewed health assessments of inter-facility transfers (inmates already in the system arriving at a new correctional centre). At three centres inspected this was limited to a brief visual check of the transferred inmate and a review of any outstanding health appointments in the PAS system. The ability to conduct a thorough assessment is challenging in centres with a large turnover of transit inmates such as Tamworth, Shortland and Cessnock CCs. At the time of inspection, these centres often accommodated inmates for short stays as they are moved between correctional centres in northern NSW to Metropolitan Sydney. Since the inspection, Kariong correctional centre has been repurposed to a transit centre, where inmates stay a maximum of 24 hours, to facilitate the movement of inmates from Metropolitan Sydney to northern NSW. This should reduce the number of interfacility transfers between correctional centres.

It is important that inmates have a health assessment while in transit if they are being accommodated overnight to ensure any immediate risks are identified. Moreover, it is critical that inmates have a thorough health assessment upon admission to any correctional centre.

532 Aboriginal and Torres Strait Islander burden of disease is 2.3 times greater than the non-Indigenous burden; see Australian Medical Association, *2018 AMA Report Card on Indigenous Health, Rebuilding the Closing the Gap Health Strategy* (22 November 2018) 5. Aboriginal people are approximately 3.5% of the NSW population yet account for approximately 25% of those incarcerated; see Simon Corben and Helen Tang, NSW Inmate Census 2018: Summary of Characteristics (Statistical Publication, Department of Corrective Services (NSW), August 2019) 52; Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians*, *June 2016* (Catalogue No3238.0.55.001, 31 August 2018) <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001#>.

533 Currently training is moving to an online training format for RSA education and training in My Health Learning, Information provided by JH&FMHN, 21 February 2021.

534 JH&FMHN, Transfer and Transport of Patients, 1.359, p1

535 The Transfer In and Out process is now electronic, Information provided by JH&FMHN, 21 February 2021.

536 JH&FMHN, Transfer and Transport of Patients, 1.359, p7.

537 Information provided by JH&FMHN, 21 February 2021.

Good practice was observed at John Morony CC and Junee CC where all receptions including interfacility transfers were subject to a thorough health assessment lasting 15-20 minutes. This included a full set of clinical observations and referral to primary health and other speciality services based on identified risk or need. The thorough screening allowed more opportunities for information gathering and health education by nurses. Testing for BBVs and STIs was also offered to all new transfers into the centre. As with RSAs, interfacility reviews by health staff are required to identify risks and needs as well as improve inmate engagement with health services.

In addition to the current transfer in and out process patients are now being screened for COVID-19 at every centre, which gives staff the opportunity to assess patients who are unwell. Private providers are contractually required to use the same transfer in and out process as that used by JH&FMHN.[537]

Recommendation 28: JH&FMHN and private health providers ensure the health screening process for interfacility transfers is optimised by a thorough health assessment

4.1.2 Accessing the health centre

In order for an inmate to access health services for non-urgent matters, JH&FMHN policy requires an inmate to complete a *Patient Self-Referral* form. These are obtained from a custodial officer or health information racks in health centres. JH&FMHN policy states:

> *The forms are filled in by the patient or their representative and placed in locked boxes which must be located in the accommodation areas to allow unfettered access. To ensure confidentiality, only JH&FMHN staff have access to these locked boxes. The forms may also be delivered directly to the Health Centre by the patient.*

The form system was the main mechanism for accessing the health centre at all of the centres inspected except for John Morony CC. Locked letter boxes were observed in accommodation areas at Junee CC. However, locked boxes that allow for the discrete and private submission of forms were not in all accommodation areas at correctional centres as per JH&FMHN policy.[538] Accordingly, inmates had to submit their forms directly to custodial officers. The inspection team observed some custodial officers reading the forms. This raises concerns around inmate privacy. Further, there was no system to guarantee forms arrived securely to the health centre. As a consequence, sometimes forms go missing, and are not always received by the health centre.[539] It did not appear that the form-based system was working effectively at Cessnock CC.[540] Inmates described having to put in multiple forms before being called up to the health centre, and in some cases inmates never received follow up.[541] Inmates told the inspection team they had 'given up' trying to access the health centre.[542]

An auditable process to record and confirm requests should be urgently implemented at all correctional centres. There is currently a risk that forms are not being received, and if they are, what is described is assessed as a low priority and the inmate is not seen. The clinical risk of a significant health issue being missed, by relying on this system is too high. Parklea CC has introduced an acknowledgement slip that provides confirmation that a Patient self-referral form had been submitted. All correctional centres should adopt a similar process.

538 Cessnock CC, Shortland CC and Tamworth CC.

539 Interviews with staff and inmates.2018.

540 Interviews with staff and inmates 2018.

541 Interviews with inmates 2018.

542 Interviews with inmates 2018.

543 Corrective Services NSW, *Inmate Health Needs* (Custodial Operations Policy and Procedures, Policy 6.3, Inmate Health Needs) 4.

The form-based system also disadvantages inmates of lower literacy levels, whose requests depend on their ability to articulate themselves, as well as their ability to identify health needs and their urgency. In some cases, inmates must rely on others to complete their forms for them, which raises privacy and confidentiality issues. The NSW Health Care Interpreter Service (HCIS) provides assistance to inmates who have difficulty in communicating in English in relation to health matters.[543]

Given the known numeracy and literacy challenges within the correctional population, reliance on self-diagnosis or self-documentation of presenting symptoms may provide barriers to accessing health care. *Patient Self-Referral* forms are reviewed and triaged daily by a RN who enters information into a software system called PAS. This is a 'sight unseen' triage process relying on the person requesting the appointment to appropriately document their symptoms in a manner which will describe the urgency of the condition. If the RN triaging the request has concerns regarding the presenting symptoms documented, they should escalate the person on the waiting list or call the inmate to the clinic for urgent review.

The RACGP *Standards for health services in prisons* states:

> *It is important that prisoners normally have direct access to the health service to make an appointment and do not routinely have to rely on others, such as prison staff within the facility, to mediate their request for access to healthcare or to identify medical needs. […]It may not be possible for prisoners to contact a health service by telephone to make an appointment, and written requests for an appointment could prove difficult for prisoners with low levels of literacy. Health services may therefore need to devise special strategies for prisoners to request an appointment […]It is important for health services to document in a patient's health record any delay between a request for healthcare and the provision of that healthcare, including the reason for the delay.*

John Morony CC used a different system to facilitate access to the health centre. Each accommodation area was designated a day of the week when they could present to the health centre in person. Inmates were also able to request health services from nursing staff when attending the clinic for medication administration. This process is somewhat similar to the process in the community where a person requiring medical assistance would self-assess the urgency of their condition. A patient may book an appointment at a General Practice or present themselves to an Emergency Department where they would be triaged and prioritised based on the urgency of their condition. The arrangement at John Morony received positive feedback from the inmates (though it is noted the system disadvantages inmates with limited mobility). Similarly, at Junee CC inmates could request permission from a custodial officer to access the health centre to make a request in person.[544] The inspection team supports this good practice as a supplement to the paper-based system.

Due to the security requirements of maximum security correctional centres, or the protection requirements of particular individuals, direct access to the health centre will not always be possible. Technology solutions such as tablets are another way of providing direct access to the clinic.[545]

Recommendation 29: CSNSW and health providers work together to allow inmates to access the clinic to make requests in person to supplement the paper-based request system; explore mechanisms for improving access to the clinic for lower literacy and lower mobility inmates; and implement auditable systems that record requests for health services

544 The collaboration between health services staff and custodial staff at Junee CC aligns with GEO's Continuum of Care Model, Information provided by GEO 21 January 2021.

545 Clarence CC has introduced tablets that allow inmates to request appointments, OV Report January 2021.

546 Clarence CC has introduced tablets that allow inmates to request appointments, OV Report January 2021.

Recommendation 30: CSNSW and private providers ensure paper-based self-referral forms and locked boxes are freely available to inmates in a number of settings including accommodation, library and employment areas to allow unfettered and confidential access

During hours when inmates are locked in cells, they have access to an intercom system which is to be used for notifying supervising custodial staff of emergency medical issues. Responding to this system in a timely manner is important for access to health services. The NSW Coroner found regarding a death in 2015 at the HRMCC that:

> *If Corrective Services Officers had responded appropriately to the intercom calls, it is likely that [the deceased] would have received medical treatment and his death would have been prevented.*[546]

The NSW Coroner made a number of recommendations regarding the intercom system at the HRMCC including 'That a corrective services officer who receives a knock up call records the call, the action taken (if any) and the officers involved.'[547] While inspections found no particular evidence of problems with intercoms, the inspector supports rigorous record-keeping to monitor emergency intercom use. CSNSW advise that electronic records are maintained in correctional centres where an updated intercom system is used.[548]Other facilities, including 24 hour court cells, should maintain a manual recording system.

Recommendation 31: CSNSW and private operators develop a system for recording, monitoring, and auditing after-hours intercom use

4.1.3 Access to Primary Care

The securitised environment and limited GP hours able to be allocated at each health centre means access to primary care is not at a level comparable to the community, where a person may present at a GP surgery or emergency department. Given the resource limitations and environmental constraints resulting from the securitised environment triage, prioritisation systems and waitlists must be used.

Requests are allocated with a priority level from one (P1) as the most urgent and five (P5) as the least urgent. Each P-level must be seen within a specific time period. At the time of inspection John Morony CC health centre had KPIs in relation to seeing P1 and P2 patients.

Some inmates told the inspection team about the difficulty of accessing a GP or nurse. Due to limited access hours it is possible that only high priority inmates are seen by the GP. Others with lower priority may wait for extended periods with the risk that what may have been viewed as a low risk condition may exacerbate over time leading to patient deterioration. The inspectorate team was advised of some cases where this had occurred, with poor clinical outcomes, for example, the delayed diagnosis of long term serious health condition or a delayed diagnosis of cancer.[549]

It is acknowledged that JH&FMHN and other health service providers have invested extensively in the process for reviewing and monitoring of waiting lists. However, the inspection observed variations in the use of PAS for appointments, the level of patient information recorded and transferred within JHeHs, review processes and triage occurring at each centre. Predominately this is due to the limitations in primary care nurse clinic hours, and the allocation and frequency of GP hours.

JH&FMHN senior management noted the multifactorial nature of access challenges. Due to CSNSW

547 *Inquest into the Death of Fenika Junior Tautuliu Fenika (Junior Fenika)* (State Coroner's Court of New South Wales, 2015/268972, 13 July 2018) 32.

548 Information provided by CSNSW, 4 February 2021.

549 Letter received by ICS 2018.

550 Interview with staff 2018.

operational and environmental constraints, consistent clinic access must be improved for any increased resource availability to be fully effective.

A further mechanism for better management of GP wait lists would be greater use of nurse led primary health clinics. This is supported by JH&FMHN. Advanced skilled RNs could assess and treat lower acuity patients if the presenting condition was within their scope of practice. The use of NPs in primary care would also provide greater ability and scope of assessment and treatment by non-medical staff. The advantage is the NP can prescribe medications within their scope of practice.

However, this is a challenging workforce to access and recruit due to the lengthy training period required as well as the constrained nature of their scope of practice. JH&FMHN has a number of programs that Network staff can complete that are accredited by some Universities and would contribute towards credit points for University courses. It is recommended that these programs continue to encourage nurses to complete further studies including Nurse Practitioner qualifications. An increase in investment in Nurse Practitioners would further assist the management of the GP waitlists.

Recommendation 32: JH&FMHN and private health providers further develop advanced nursing practice and Nurse Practitioners to increase the access to timely primary care.

Another barrier to primary health care and GP access is the volume of inmate movements across the correctional system. If an inmate has an appointment at their previous centre, they should be transferred on to the GP list at their receiving centre by the receiving NUM and triaged accordingly for where they should be on that list. This can be challenging for the receiving nurse who may be relying on the limited clinical information contained within the JHeHs from the request and report for the previous centre. It can also be challenging to determine if a new reception or inmate transferred from another centre is of higher or lower clinical priority in comparison to the other patients on the waiting list. Correctional centres with a high number of transfers in and out tended to spend significant time reviewing and reprioritising waiting lists. However, even centres with more stable populations reported challenges with GP access as these centres usually had lower GP hours allocated due to having a more 'stable' population.

A new functionality of JHeHs was implemented during the period of the inspection. The 'Qlik View' app was launched across all JH&FHMN in October 2018. This shows the waitlist of a given centre, how many inmates are priority one or two, which patients are exceeding the recommended timeframe for a priority level, and if the patient has been transferred.[550] This is a positive approach to wait list management.

Inmates reported long waits to be called up to a clinic at all centres, and no system to let inmates know their appointment time due to 'security' reasons. The inmates interviewed expressed frustration when being re-triaged after being transferred between centres. They felt they waited for their appointment for a long period, progressed up the waiting list and then were moved down the list if they had been received into another centre with a differing mix of patient need. This was reported by inmates as being particularly apparent with dental waiting lists. Contributing factors included a high volume of requests for review, changing clinical need, limited dental hours, variation of dental hours between centres and CSNSW operational constraints limiting the number of patients allowed in the clinic at any one point.

Several centres had mental health nurses within their staffing profile. These positions provide a highly effective triage and clinical review function to support the psychiatry clinics as well as short term intervention and mental health support. However, the positions at a number of centres had been vacant for long periods despite recruitment and retention efforts. The absence of a mental health nurse creates problems for effective triaging of the psychiatry list. Where a mental health nurse was present, there remained resourcing and review challenges, but these locations did have a greater understanding of clinical priority for

551 Interview with staff 2018.

psychiatry review and a capacity to manage these competing priorities. Psychiatrists felt it was important for a mental health nurse to undertake triaging for the psychiatrist list. At Shortland CC (formerly Cessnock 3-4), the psychiatrist list was triaged by a primary health nurse, resulting in some high-risk inmates being overlooked.[551]

4.1.4 Wait lists for JH&FMHN based General Practitioners/Medical Officers & Primary Health Nurses

Wait times between a patient being placed on a waitlist to seeing a nurse or medical practitioner can be lengthy and depend on their assessed priority level; P1 being the most urgent and P3 for non- urgent. P1 should be seen within 1-3 days; P2 in 3-14 days, P3 14 days to three months. P4 are for routine appointments within 12 months and P5 for follow up appointments.[552] Figure 5 shows that many centres did not see P1 and P2 patients within the required timeframes. Nine of the 38 centres met the required timeframe based on average wait times (See Figure 15). As priority is given to P1 and P2 patients, P3 patients can wait exceedingly long times or not seen at all.

Workflows and streaming of these different patient groups need to be a key focus in the future. It should be acknowledged that when a health issue is triaged to a P3 or lower it does not mean that a clinical risk does not persist. In an emergency department it is recognised that P3 level patients, albeit not acute, still need to be seen within a reasonable timeframe. In hospital settings advance nurse practice clinics allow for the streaming of this workload. Chronic health conditions may become acute if not appropriately monitored and health interventions applied.

Table 23 below shows priority 1 and 2 waitlists (number of days waiting) for primary health nurse and GP at JH&FMHN correctional centres for the period 2017-2018.[553]

Table 23: Average wait times (days) for primary health care during 2017-18

Health centre	GP		Primary Health nurse	
	P1	P2	P1	P2
Bathurst CC	29	30	21	27
Berrima CC	0	18	0	8
Broken Hill CC	0	35	0	18
Cessnock CC	48	27	3.3	13
Shortland CC	0	0	0	0
Cooma CC	6	21	5	7
Dawn de Loas CC	11	21	15.5	28
Dillwynia CC	4	21	0	25
Emu Plains CC	0	12	11	8
Glen Innes CC	10	21	0	20
Goulburn CC	10	26	0	32
Grafton CC	4	18	3.2	11

552 PAS Waiting List Priority Level, November 2018; Information provided by JH&FMHN 21 February 2021.

553 Information provided by Justice Health and Forensic Mental Health Network 2018.

554 Information provided by Justice Health and Forensic Mental Health Network, 30 April 2019.

Hunter CC	29	50	12	11
Illawarra Reintegration Centre	0	15	2	27
Ivanhoe Work Centre	0	0	0	33
John Morony 1 CC	8	14	4	7
Junee CC	6	5	5	10
Kariong CC	11	20	5	13
Kirkconnell CC	0	59	14	29
Lithgow CC	26	33	5	36
Long Bay Hospital	35	44	216	135
Macquarie CC	30	31	0	9
Mannus CC	2	40	0	23
Mary Wade CC	16	33	1	9
Mid North Coast CC	2	16	6	12
MMTC	17	26	18	20
MRRC	8	15	3	7
MSPC 1	13	28	37	22
MSPC 2	19	21	30	14
MSPC 3	19	40	18	52
Silverwater Womens CC	11	11	11	9
Oberon CC	0	0	0	15
OMMPC	0	28	2	29
Parklea CC	9	20	24	23
South Coast CC	32	32	16	16
St Heliers CC	0	11	0	5
Tamworth CC	3	7	2	4
Wellington CC	4	23	14	19

Table 24 shows the number of GP hours to each centre by month for the period January 2017 to February 2019. The data shows that for some centres, the average GP hours worked per month was less than the hours allocated to the centre.[554] A number of centres with lengthy average wait times did not have a GP work their contracted hours. This confirmed inmate sentiment at Cessnock and Shortland CCs; that it took a long time to access a GP. Moreover, GP absences may be a factor in inmates missing out on care at some centres. Conversely, insufficient contracted hours may contribute to lengthy waitlists at other centres.

555 Information provided by Justice Health and Forensic Mental Health Network April 2018. Note, these are averages.

Table 24: Number of GP Hours Per Centre Month During the Period of January 2017-February 2019

Centre	Contracted Hours Per Month	Currently Hired Hours	Average Hours Worked Per Month
Statistics from January 2017 to February 2019			
Berrima	8	0	8
Broken Hill	4	4	4
Bathurst	40	16	36
Cessnock Main	32	32	44
Cessnock Max (Shortland)	64	32	25
Cooma	24	24	24
Dawn De Loas	32	32	32
Dillwynia	32	32	32
Emu Plains	48	48	35
Forensic Hospital	8	0	8
Frank Baxter	32	32	32
Goulburn	72	72	82
Glen Innes	16	16	16
Grafton	36	36	16
Hunter	32	36	16
IRC	8	0	8
John Morony	64	64	64
Kariong	8	0	8
Kirkconnell	16	8	8
LBH-KWU	8	0	8
LBH-MSU	128	128	97
Lithgow	24	24	24
Mannus	8	0	8
Macquarie	32	32	32
MMT 12/13	96	96	44
Mid North Coast	102	84	80
MRRC Darcy	32	32	16
MRRC G Block	32	32	32
MRRC H Block	32	32	16
MRRC J Block	128	128	128
MRRC MHSU	32	32	32
MSPC1	48	48	40
MSPC2	64	48	56
MSPC3	96	96	80
Silverwater Womens	64	64	64

Mary Wade	16	16	8
Oberon	PHNP (GP as required)		
OMMPC	32	32	32
Parklea CDTP	8	8	4
Parklea	128	128	96
St Helliers	24	24	24
South Coast Min	16	16	16
South Coast	64	64	48
SPC	16	16	12
Tamworth	16	16	12
Wellington	72	72	64
TeleGP (Various centres)		96	96

Table 25 below shows wait times in days for priority 1 and 2 patients for different clinical streams at JH&FMHN correctional centres for the period 2017-2018.[555]

Table 25: Average Waiting Times (in days) for Clinical Streams During the Period of 2017-18

Health centre	MH Nurse		Psychiatrist		D&A nurse	
	P1	P2	P1	P2	P1	P2
Bathurst	2	21	0	38	1	16
Berrima CC	0	28	0	14	0	28
Broken Hill CC	0	26	0	0	0	0
Cessnock CC	2	17	4	23	0	21
Shortland CC	0	0	0	0	0	0
Cooma CC	0	0	0	202	0	8
Dawn de Loas CC	11	26	12	38	7	0
Dillwynia CC	8	23	43	54	0	1
Emu Plains CC	1	25	0	28	0	31
Glen Innes CC	0	0	0	0	0	0
Goulburn CC	4	14	3	46	0	0
Grafton CC	0	6	0	4	133	12
Hunter CC	0	112	0	245	0	0
Illawarra Reintegration Centre	0	0	0	0	0	0
Ivanhoe Work Centre	0	0	0	0	0	0
John Morony 1 CC	7	14	24	23	0	2
Junee CC	9	34	0	120	3	10
Kariong CC	0	0	0	0	0	0

556 Information provided by JH&FMHN 2018.

Kirkconnell CC	0	26	0	0	0	0
Lithgow CC	53	67	0	60	0	7
Long Bay Hospital	0	35	0	20	1	0
Macquarie CC	0	58	0	0	8	34
Mannus CC	0	11	0	0	0	0
Mary Wade CC	0	34	0	27	0	0
Mid North Coast CC	0	11	0	5	0	10
LBH2	72	66	34	43	0	37
MRRC	3	8	16	16	1	2
MSPC 1	0	73	6	50	0	0
MSPC 2	4	48	0	64	0	0
MSPC 3	17	51	172	73	0	0
Silverwater Women's CC	17	11	37	25	0	4
Oberon CC	0	0	0	0	0	0
OMMPC	12	27	12	24	0	29
Parklea CC	11	16	35	31	0	2
South Coast CC	3	22	84	9	13	17
St Heliers CC	0	0	0	0	0	0
Tamworth CC	1	5	0	0	0	0
Wellington CC	1	19	1	22	0	15

This demonstrates that in many cases, high priority patients wait for lengthy periods to receive mental health and drug and alcohol services. Lengthy wait times may mean that people become more unwell and require more serious medical intervention at a later date. It is noted that a 'Qlik View' app was launched cross all JH&FHMN in October 2018. This shows the waitlist of a given centre, how many inmates are on priority one or two, which patients are exceeding the recommended timeframe for a priority level, and if the patient has been transferred.[556] JH&FMHN and other health service providers need to determine what is contributing to waitlists at each centre and develop local action plans in consultation with CSNSW to address waitlists.

Recommendation 33: JH&FMHN and private health providers continue to explore innovations in managing waitlists, and consider appropriate targets for waiting times for each health service and mitigation action if these are not met

4.1.5 Attendance at primary care appointments

Lengthy wait times combined with rates of GP or primary health nurse appointment non-arrivals indicate that access to doctors and nurses is indeed a challenge for inmates. Data provided by JH&FMHN for the period 2017-2018 shows that at several centres, over 30% of booked GP appointments did not arrive. At one centre over 50% of appointments did not arrive.[557]

557 Information provided by Justice Health and Forensic Mental Health Network January 2019.

558 Information provided by Justice Health and Forensic Mental Health Network, 30 April 2019.

Table 26: Arrival Rates for GP and Primary Health Nurse Appointments (aggregated) During the Period of 2017-18.

Health Centre	Appointments booked	Appointments arrived	% arrived
DDL1	3	1	33
Parklea	2813	1352	48
Mary Wade	147	89	61
Bathurst	724	442	61
Silverwater Womens'	1898	1206	64
Goulburn	1880	1204	64
Lithgow	750	486	65
MNC	1665	1108	67
Cessnock Main	703	480	68
SCCC	1384	955	69
Glen Inness	511	365	71
Dillwynia	1058	764	72
OMMPC	619	448	72
MSPC2	1064	782	73
Tamworth	460	344	75
DDL2	753	571	76
MMTC	1733	1316	76
Hunter	132	105	80
John Morony	972	792	81
Cessnock Max	196	160	82
Grafton	518	424	82
Kirkconnell	165	142	86
Wellington	1340	1159	86
Emu Plains	871	767	88
MSPC1	729	642	88
Macquarie	175	155	89
Berrima	248	221	89
Mannus	111	99	89
MRRC	2983	2679	90
Broken Hill	120	108	90
St Heliers	412	372	90
Compulsory Drug Treatment	143	131	92
Kariong	138	127	92
SPC	120	111	93
MSPC3	785	742	95
LBH	81	79	98
Cooma	466	462	99
Illawarra Reintegration	49	49	100
Ivanhoe	11	11	100

Recorded reasons for non-arrivals to GP appointments for the period 2017-2018 are below:

Table 27: Reasons for GP Non-Arrivals at All Centres (aggregated) During the Period of 2017-18

Reasons for GP non-arrivals, all centres, 2017-2018		
Reason code	Number	% of all cancellations
Appt made in error	308	11.8
T Pt transferred	286	10.9
C5 Pt in another centre at appt time	260	9.9
C7 Cancelled by DCS	216	8.3
RL Patient released from custody	212	8.1
Patient Unable to Attend	195	7.5
No longer required	182	7.0
P1 Cancelled by Pt	179	6.8
DNA Did not answer page or other reason	152	5.8
A2 Urgent appt takes priority	134	5.1
H1 Cancel by specialist	89	3.4
H3 Cancel by H. Provider	81	3.1
Specialist cancelled clinic	64	2.4
CO Pt at court	63	2.4
A1 Other escort took longer than planned	46	1.8
Clinic notification error	42	1.6
MRD Appointments staff cancelled	40	1.5
H2 Cancelled by triage nurse (psych)	24	0.9
Treated elsewhere	18	0.7
C3 Not transferred centre closure	6	0.2
Patient error	5	0.2
Patient unwell	4	0.2
Died	3	0.1
AN Annex escort	2	0.1
C1 In LBH2 but did not arrive	1	<0.1
C4 Med. escort team cancels	1	<0.1
EHR Extra High Risk	1	<0.1
P2 Pt from non LBC	1	<0.1
Total cancellations	2615	100

As discussed earlier, inmates are often transferred to another centre before they reach the top of the waitlist and have their appointment. Over 20% of patients who did not attend their appointments had been transferred to another centre but not removed from the waitlist. Nearly 10% had been released from custody

but had not been removed from the waitlist. Approximately 20% of appointments were cancelled by patients. This is a poor use of GP time and does not assist in reducing the size of the waitlist or the length of time patients spend on a waitlist.

The inspection team also reviewed data on the rate of primary health clinic appointments booked compared with patients who arrived for their appointment.[558]

Table 28: Primary Health Nurse Clinic Appointments Booked vs Arrived for the Period 2017-2018

Clinic Name	Booked:	Arrived:	% arrived
Dawn De Loas Area 1 Primary Health Nurse Clinic	72	19	26
Parklea Area 3 Clinic Primary Health Nurse	3507	2057	59
Dawn De Loas Area 2 PH Nurse Practitioner Clinic	22	15	68
Parklea Area 5 Clinic Primary Health Nurse	4563	3206	70
Grafton Units Primary Health Nurse Clinic	1884	1408	75
Grafton JBC Primary Health Nurse Clinic	410	317	77
Bathurst X Wing Primary Health Nurse Clinic	1976	1530	77
MRRC J Block Fordwick Primary Health Nurse	9404	7293	78
Goulburn Main Primary Health Nurse Clinic	8062	6256	78
Silverwater Womens Primary Health Nurse Clinic	27186	21206	78
Junee Primary Health Clinic	11948	9334	78
Mary Wade Primary Health Nurse Clinic	2167	1756	81
Emu Plains PH Nurse Practitioner Clinic	168	137	82
John Morony 1 E Unit Primary Health Nurse Clinic	70	58	83
MRRC Goldsmith Primary Health Nurse	9594	7978	83
Goulburn HXM Primary Health Nurse Clinic	2810	2353	84
MRRC Hamden Primary Health Nurse	7108	5983	84
MRRC J Block Darcy Primary Health Nurse	20438	17204	84
Dillwynia Primary Health Clinic	10717	9028	84
South Coast Main Primary Health Clinic	11466	9883	86
MMTC 12 Wing Primary Health Nurse Clinic	19059	16491	87
South Coast Sector 3 Primary Health Nurse Clinic	4310	3735	87
Parklea Primary Health Nurse Clinic	13729	11915	87
Bathurst Main Primary Health Nurse Clinic	14795	12845	87
Grafton Primary Health Nurse Clinic	14119	12438	88
Tamworth Primary Health Nurse Clinic	5234	4614	88
Mid North Coast Primary Health Nurse Clinic	18307	16191	88
Shortland Primary Health Clinic	14663	13004	89

559 Information provided by JH&FMHN December 2019.

Clinic Name	Booked:	Arrived:	% arrived
OMMPC Primary Health Nurse Clinic	6038	5367	89
Parklea Area 4 Clinic Primary Health Nurse	2393	2144	90
Lithgow Primary Health Nurse Clinic	12013	10820	90
Goulburn HRMU Primary Health Nurse Clinic	2075	1878	91
IRC Primary Health Nurse Clinic	2954	2688	91
Dawn De Loas Area 2 Primary Health Nurse Clinic	22497	20584	91
Hunter Primary Health Nurse Clinic	4032	3690	92
Kariong Primary Health Nurse Clinic	2409	2209	92
LBH ACRU Primary Health Nurse Clinic	25	23	92
Oberon Primary Health Nurse Clinic	2439	2264	93
Bathurst ACMU Clinic Primary Health Nurse	2168	2022	93
MMTC 13 Wing Primary Health Nurse Clinic	4290	4010	93
Berrima Primary Health Nurse Clinic	5743	5391	94
MRRC J Block PM Primary Health Nurse Clinic	9709	9132	94
Emu Plains Primary Health Nurse Clinic	8207	7749	94
MSPC 1 Primary Health Nurse Clinic	20274	19151	94
Cessnock Main Primary Health Clinic	18450	17491	95
Oberon PH Nurse Practitioner Clinic	77	73	95
Macquarie Primary Health Nurse Clinic	4274	4074	95
Kirkconnell Primary Health Nurse Clinic	7757	7410	96
South Coast Sector 2 Primary Health Nurse Clinic	142	136	96
South Coast G Pod Primary Health Nurse Clinic	5674	5466	96
Cooma Primary Health Nurse Clinic	4735	4573	97
MSPC 2 Primary Health Nurse Clinic	16800	16557	99
St Heliers Primary Health Nurse Clinic	8475	8383	99
Ivanhoe Primary Health Nurse Clinic	501	498	99
Glen Innes Primary Health Nurse Clinic	7655	7621	100
Brewarrina Primary Health Nurse Clinic	1449	1448	100

Reasons for PH nurse clinic non-arrivals were as below:

Table 29: JH&FMHN Reasons for Primary Care Nurse Clinic Non-Arrivals for All Centres (aggregated) for the Period of 2017-2018

Reason	Number	Percentage of all
A1 Other escort took longer than planned	1899	15
A2 Urgent Appointment takes priority	1719	14
AN Annex escort	1466	12
Appointment made in error	1046	9
C1 In LBH2 but did not arrive	1009	8
C3 Not transferred centre closure	885	7
C4 Med escort team cancels	786	6
C5 Patient in another centre at appointment time	772	6
C7 Cancelled by DCS	674	5
Clinic notification error	358	3
CO patient at court	301	2
Died	252	2
DNA Did not answer page or other reason	250	2
EHR Extra High Risk	169	1
H1 Cancel by specialist	143	1
Cancelled by triage nurse	129	1
H3 Cancel by H. Provider	77	1
MRD Appointments staff cancelled	76	<1
MRD MAU cancelled	58	<1
No longer required	56	<1
Not Specified	34	<1
P1 Cancelled by Pt	34	<1
P2 Patient from non LBC	22	<1
Patient delivered	18	<1
Patient error	14	<1
Patient Unable to Attend	11	<1
Patient unwell	10	<1
Patient from country centre not escorted	5	<1
RL Patient released from custody	2	<1
Specialist cancelled clinic	2	<1
T Patient transferred	1	<1
Treated elsewhere	1	<1
Total	**12279**	**100**

Between 27% and 100% of inmates attended their primary health appointments. The reason for most non-arrivals was due to CSNSW not bringing the patient to the health centre. This was closely followed by JH&FMHN cancelling the appointment because of an urgent matter taking priority. A small percentage of inmates decided not to attend their appointment.

The demand for health services clearly outweighs the supply of health services. An increase in primary health and GP clinic hours may assist in addressing demand. However, the above data on reasons for non-arrivals suggests that in many cases, limitations to access are beyond the control of JH&FMHN. This demonstrates that CSNSW can also play a role in improving access to health care. Facilitating efficient movement to and from the clinic would reduce the number of non-arrivals for GP and primary health clinic appointments. Increasing the hours in which JH&FMHN can see patients may also improve access to care.

JH&FMHN acknowledge that more work is required to improve patient flow, and scheduling to reduce downtime.[559] A more consistent approach to the numbers of inmates allowed within clinics, increased hours of access to inmates for health services and more efficient 'staging' of inmates close to the clinic would all contribute to higher numbers of patients being seen by JH&FHMN and a more efficient correctional primary care health system.

Each correctional centre should be required to develop an action plan to increase patient access to the health centre for treatment from 0800hr – 1130hr and 1230hr to 1430hr. CSNSW should allocate a clinic officer position in all maximum and medium security centres as this is integral to ensuring adequate patient access to the clinic. Progress against the action plans should be reported monthly through the local centre management meeting and JH&FMHN.

Better governance is also required to minimise the impact of non-arrivals to clinics. JH&FMHN is working on improving governance of internal appointments processes, including ensuring that patient cancellations are informed decisions made in conjunction with health staff.[560]

It is acknowledged that at the time of inspection JH&FMHN had a *GP Redesign Project* underway. The project aims to:

- to improve access to targeted and equitable GP services by decreasing average waiting times
- increase the average number of patients seen per GP clinic
- decrease the number of patients on the GP waitlist with no appointment
- ensure 100% of patients waiting >99 days are reviewed by a GP or registered nurse to reassess the primary complaint.

This is welcomed not only because GPs are required to attend correctional centres as regularly and frequently as is necessary to comply with the GPs statutory obligations[561], but because GPs provide a critical service to the correctional health system. They prescribe medication and they refer patients to specialists.[562] For example, if an inmate may have cancer, they need to be referred by the GP to an oncologist.

JH&FMHN and other health providers need to develop a model that ensures the most sick and vulnerable can access GP services. This will assist in mitigating the risk of late diagnosis of chronic or terminal

560 Information provided by JH&FMHN 2018.

561 Section 236C(4) *Crimes (Administration of Sentences) Act 1999*.

562 Nurse Practitioners are also able to undertake these functions.

563 Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population' (Report, April 2015) 11.

illnesses. It should also reduce the need for emergency escorts as a result of deteriorating health requiring hospital admission.

All health providers need to make GP clinics more effective and increase the average number of patients seen per GP clinic. This could be assisted by primary health nurses performing pre-assessment for greater efficiency to determine short consultations for prescriptions, and longer consultations for more complex assessments. JH&FMHN should continue to examine clinic level data for GPs and develop solutions to improve performance where required.

JH&FMHN also need to make sure that GP absences are covered by locum GPs or through telehealth. JH&FMHN advise that they ensure GP absences are covered. The GP hours worked, and non-arrival data suggest otherwise.

Recommendation 34: JH&FMHN and private health providers and CSNSW and private operators develop an action plan for each correctional centre to increase patient access to the health centre for treatment from 0800hr – 1130hr and 1230hr to 1430hr and provide sufficient escort and supervision to allow all clinic rooms to be utilised for maximum efficiency

Recommendation 35: JH&FMHN and private health providers should continue to examine clinic level data for GPs and develop solutions to improve performance where required.

4.2 Constraints upon accessing health centres

4.2.1 Physical infrastructure of health centres

The Physical infrastructure of health centres impacts patient flow. The size of health centres, the number and use of rooms, and the location and number of waiting areas impacted the number of inmates who could be seen on a given day. In most centres inspected, rooms were used for a combination of consultation, treatment, and storage of medical records and disposable supplies.

This office found in 2015 that while extra accommodation beds, including double bunks, had been installed in correctional centres to accommodate increasing inmate numbers, health infrastructure and services had not been increased proportionally.[563] Inspections for the current report identified the same concerns. In many cases, the size and profile of the inmate population had grown without a commensurate increase in health centre infrastructure.

The inspection team heard that capital works to accommodate increased inmate numbers often focus on accommodation areas, and do not consider clinical requirements or how to optimise patient flow in the health centre.[564] This raised concerns around maintaining accreditation, privacy and safety. There may be adverse implications for the adequate provision of care if health infrastructure is not commensurate with inmate numbers. At the time of inspection, the health centre at Cessnock was no longer fit for purpose. Since the inspection, CSNSW has delivered 12 new health clinics and upgraded 3 existing clinics as part of prison expansions at the following locations: Bathurst CC, Cessnock CC, Shortland CC, Dillwynia CC, Goulburn CC, Hunter CC, Junee CC, Macquarie CC, Mid North Coast CC, Metropolitan Remand & Reception Centre, Parklea CC and South Coast CC.[565] This is to be commended.

GEO has also developed a policy which addresses the benefits of input from health services staff and senior leadership team members at the Centre in the development or redevelopment, commissioning and

564 Interviews with staff 2018.

565 Information provided 4 February 2021.

566 Information provided by GEO 21 January 2021

maintenance of health facilities.[566]

The inspection team observed instances where inmates were held in what was termed a 'medical cell'. This was usually a cell with little to no soft furnishings, in close proximity to the health centre. It is understandable that these cell placement decisions are required to allow more ready access to a patient by JH&FMHN staff for clinical care delivery and to conduct observations. However, at times these locations were used to accommodate inmates who were unable to function appropriately within an accommodation unit. For example, the patient/inmate required additional support in relation to showering or activities of daily living.[567] Clarity around the use, function, protocols and cross agency responsibilities for the use of 'medical cells' should be considered.

Further, the need for custodial officers to supervise medical consultations in cramped conditions sometimes resulted in compromised privacy for inmates. Maintaining privacy, confidentiality and managing inmates with multiple classifications, non-association status or protection status is challenging and places further pressure on patient flow in health centres. The privacy of inmates receiving supervised medication at dispensing windows is also important in order to mitigate against the risk of standover. There is existing CSNSW legislation and policy around maintaining inmate privacy and confidentiality and preventing unauthorised disclosure.[568] The ongoing challenge is to ensure this occurs in practice.

Recommendation 36: CSNSW ensure that all future capital works for health centres are:

- **a) designed with the collaboration of JH&FMHN or the relevant private health provider from the outset**
- **b) commensurate to the size of the inmate population**
- **c) designed with privacy and flow in mind, for example, sufficient holding rooms, waiting areas, screening of medication dispensing areas from correctional centre traffic, and large windows for supervision and line of sight without audibility**

Recommendation 37: CSNSW or private operator staff assisting with health centre escorts and supervision ensure that inmate privacy and confidentiality is maintained.

4.2.2 CSNSW role in access to health care

Custodial staff play a critical role in access to health care. In 2015 this office identified that while JH&FMHN staff shifts are organised at the local level, patient access to a fully staffed health centre may be constrained by custodial staff. It was found that the number of patients who can be seen during normal health centre operating hours is impacted by correctional centre operating routines, the number of custodial staff on shift, the number of unscheduled lock downs, and the number of out-of-cell hours.[569]

This office recommended that 'CSNSW and JH&FMHN work together to develop policies and procedures that improve inmates' access to health services when there are staff shortages and lockdowns'.[570] CSNSW responded that 'Inmates' access to health services will be improved through the implementation of

567 Frail and incontinent inmates were being accommodated in observation cells adjacent to the health centre at Cessnock 3-4 (now referred to as Shortland CC)

568 *Crimes (Administration of Sentences) Regulation 2014* Clause 288(2); Custodial Operations Policy and Procedures(COPP), section 22.4 Medical records and health information.

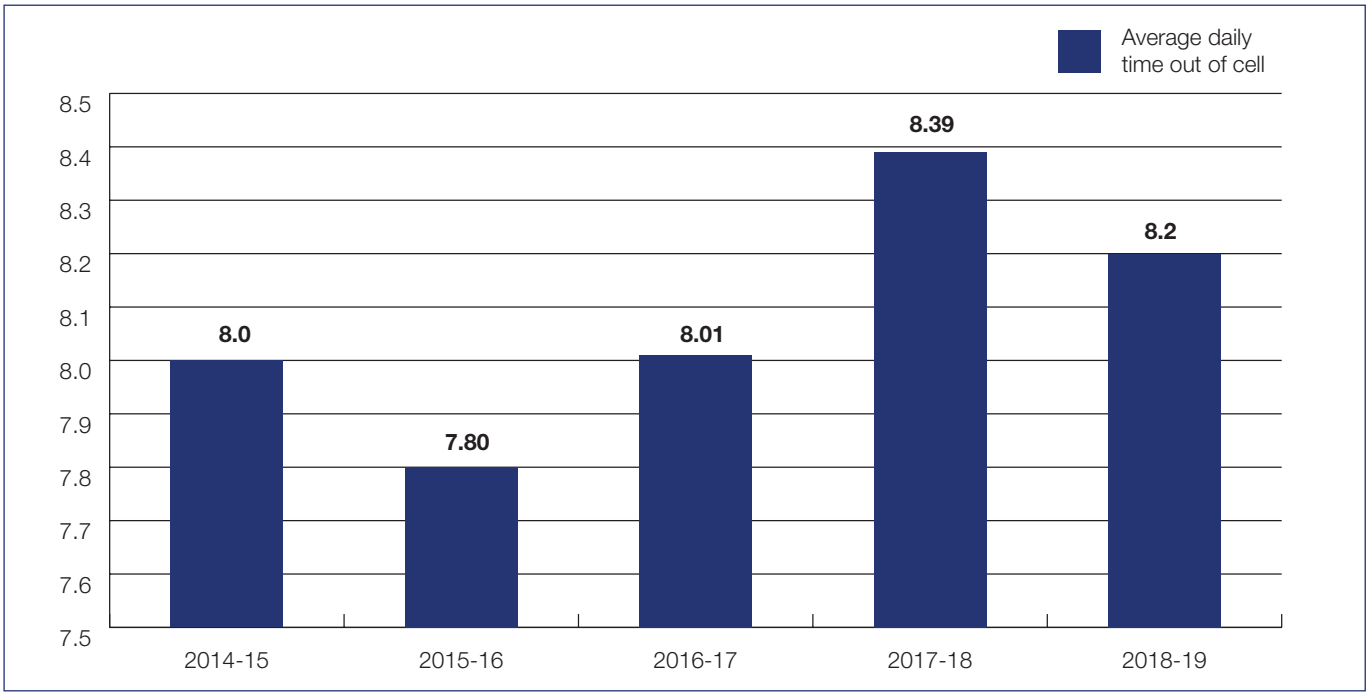
569 Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population' (Report, April 2015) 56.

570 Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population' (Report, April 2015) 57, recommendation 19.

571 Information provided by CSNSW, November 2017. Benchmarking of all NSW correctional centres occurred over 2016 – 2018 at the request of the NSW Government. Benchmarking involves setting staffing levels and performance targets across all publicly-run correctional centres to allow improved performance monitoring, with Governors responsible for individual centre performance. See: CSNSW 'Better Prisons Performance targets and Benchmarking fact sheet #2'; CSNSW 'Let the leaders lead' https://www.correctiveservices.justice.nsw.gov.au/Documents/Let-the-Leaders-Lead.pdf

"benchmarking" which is being rolled out across the state.'[571] Figure 10 shows that overall, average hours out of cell have increased since benchmarking was implemented.

Figure 10: CSNSW trends in time out of cell, combined open and secure custody



Nevertheless, inspections for this report identified constraints to health centre access similar to those found in 2015. This includes the impact of unplanned lockdowns, known as Varied Operational Routines (VOR). VORs mean inmates from some or all accommodation areas are locked in their cells when they would normally be out of cells. VORs may result from incidents such as security breaches or an unplanned emergency medical escort out of the centre. If the centre is short-staffed, these events may be even more likely to trigger a VOR as there is insufficient staff to maintain safety and security.

VORs mean health centres cannot see patients on their primary health clinic list or GP list. This was raised as an issue by health staff during inspections. As discussed earlier, patients missing out on appointments may contribute to longer waitlists. Further, when access is limited by operational factors, health centres capacity to meet their targets is impacted, for example in relation to BBV and STI screening.[572] The data below shows the impact of VORs in medium/maximum centres in the period 2017-2018**.** It also shows that out of cell hours at Junee CC correlate with increased access to health services.

Table 30: **Average VOR and time out of cell for NSW medium/maximum security centres 2017-2018**

Correctional Centre	Regular daily routine 2017-18*	VOR Lockdown Hours**	FINAL TOC hours
SECURE CUSTODY			
Bathurst Correctional Centre	7.78	0.62	7.16
Broken Hill Correctional Centre	7.51	0.52	6.99

572 Interviews with staff 2018.

573 Information provided by CSNSW September 2020.

Cessnock Correctional Centre	7.28	0.20	7.08
Cooma Correctional Centre	8.02	0.94	7.07
Dilwynia Correctional Centre	8.10	0.52	7.58
Goulburn Correctional Centre	6.33	0.73	5.61
Grafton Correctional Centre	5.80	0.31	5.49
High Risk Management Correctional Centre	6.01	1.25	4.76
John Morony Correctional Centre (I)	7.02	0.39	6.63
Junee Correctional Centre	10.65	0.71	9.94
Lithgow Correctional Centre	6.98	0.59	6.39
Long Bay Hospital Area 1	7.85	1.12	6.73
Metropolitan Remand and Reception Centre	6.44	0.25	6.20
Metropolitan Special Programs Centre	7.06	0.35	6.71
Mid North Coast Correctional Centre	7.29	0.38	6.91
Parklea Correctional Centre	7.48	0.68	6.80
Silverwater Womens Correctional Centre	6.27	0.26	6.01
South Coast Correctional Centre	8.02	0.46	7.56
Special Purpose Centre	7.02	0.51	6.51
Tamworth Correctional Centre	6.98	0.41	6.57
Wellington Correctional Centre	8.02	0.43	7.59
24 hr and 8 hr Police/Court Cell Complexes	0.00	0.00	0.00

***** *Regular routine hours are based on routine reported in the TOC survey completed by each correctional centre.*

*** All hours lost due to variation of routine are based on incidents reported in the VOR and IRM databases*

Table 31: Daily average VOR and time out of cell by security level[573]

Measure	2017-18	2018-19	2019-20
Normal routine	7.33	8.1	8.2
Variation of routine	0.55	0.9	0.4
Daily average time out of cells	6.78	7.2	7.8

Benchmarking also included the development of Management Service Agreements (MSAs) between JH&FMHN and CSNSW at each individual centre. MSAs set out the respective responsibilities of Managers of Security and Nurse Unit Managers towards more efficient access to health services for inmates. MSAs state that during lockdowns, Managers of Security should 'make all reasonable efforts to ensure that essential services are delivered to patients' including OST, supervised medication and seeing patients requiring urgent review.[574] The Agreements also set out the maximum numbers of inmates permitted in the

574 Management Service Agreements, under Responsibilities of MOS .

575 *Memorandum of Understanding between JH&FMHN and CSNSW* 2014, p3

health centre at one time. Agreements are to be reviewed and renewed annually.

Attempts to improve collaboration have been made previously. An MOU between CSNSW and JH&FMHN signed in 2014 aimed to 'foster a collaborative partnership between the agencies'.[575] Principles of the MOU included developing Operational Level Agreements at the local level, a shared performance framework with KPIs, and reduce costs of movements for health related reasons.[576]

Despite the positive intent of MSAs, problems with access appear to persist. While current MSAs set out the distinct responsibilities of NUMs and governors, there is no shared performance framework. JH&FMHN's KPIs are oriented towards NSW Health, and CSNSW KPIs are focused on operational issues such as rates of assaults and illicit drug use.[577] Shared KPIs around health centre access may provide the performance infrastructure to achieve the goals intended in the Management Service Agreement.

A genuine culture of collaboration and communication between custodial and health providers, fostered and promoted by leadership, will help improve access to health services. Improving cooperation may be challenging and difficult to measure. However, the inspection team observed that it is possible. This was particularly evident at John Morony CC and Junee CC. Good examples observed at centres inspected included:

- health and correctional staff working together to determine why a patient did not arrive for an appointment at the health centre[578]
- correctional staff assisting a nurse to access accommodation units to follow up with a patient[579]
- multiple brief 'check ins' throughout the day between the Manager of Security and the NUM[580]
- A correctional officer approaching the health centre to provide information about an inmate who had recently had neurosurgery [581]

Recommendation 38: JH&FMHN and CSNSW jointly review Management Service Agreements to improve patient access and flow, including during lockdowns if it is safe to do so, and develop an escalation policy to trigger joint teamwork and intervention where issues emerge

4.2.3 Staffing levels and vacancies

Staffing levels and vacancies impact access to health services in custodial facilities. Health centre staff reported that recruitment in rural and remote areas is challenging, particularly for Aboriginal health worker roles and mental health nurses.[582] At three of the centres inspected, mental health nurse roles were vacant at the time of inspection due to difficulties in recruiting to the role.[583]The 2015 *Full House* report noted a community-wide shortage of mental health nurses.[584] The Aboriginal health worker role at John Morony CC was also vacant at the time of inspection.

576 *Memorandum of Understanding between JH&FMHN and CSNSW* 2014, p4-5

577 Department of Justice: Corrective Services (NSW), *Corrective Services Management of Public Correctional Centres Service Specifications* (no date) 59.

578 John Morony CC.

579 John Morony CC.

580 Tamworth CC.

581 Cessnock 3-4 (now known as Shortland CC)

582 Information provided by JH&FMHN 2018.

583 At the time of inspection, the mental health nurse roles: at Cessnock 1-2 had remained vacant for nine months despite multiple recruitment rounds; at Tamworth CC the mental health nurse had been seconded to the courts and her position at the centre remained vacant.

584 Inspector of Custodial Services (NSW), 'Full House: The Growth of the Inmate Population' (Report, April 2015) 50.

585 Information provided by GEO 21 January 2021.

GEO advise that since the time of inspection it has successfully recruited mental health and drug and alcohol positions at Junee CC.[585]

Reports of challenges in recruitment were supported by data provided by JH&FMHN. At December 2018, 10 out of 18 mental health nurse roles in correctional centres were filled.[586] At 4 March 2019 the JH&FMHN workforce had 90.7 vacancies. At 21 June 2020 the overall number of vacancies had reduced significantly, however there still appeared to be challenges in recruiting Aboriginal health workers.[587]

Table 32: JH&FMHN FTE Health Workforce Vacancies

Role	4 March 2019	21 June 2020
Registered Nurse	54.9	0
Enrolled/Endorsed Nurse	6.8	0.44
Mental Health Nurse (Ambulatory)	5	1.84
Mental Health Clinical Nurse Consultant 2Up	2	
Aboriginal Health Worker (Aboriginal Chronic Care Program)	3	4.47
Aboriginal Health Worker	4	
Drug and Alcohol Clinical Nurse Specialist	4.4	0
Nurse Unit Manager 1	2	3.44
Nurse Unit Manager 2	2	
Public Health RN	0.2	2.13
Drug and Alcohol specialist medical officer	1.4	0
Drug and Alcohol Nurse Practitioners	1.3	0
Psychiatrists (Custodial Mental Health Medical)	1.6	0
General Practitioners	2.1	1.10
Total vacancies	**90.7**	**13.42**

Staff vacancies are likely to impact wait times for health services and increase numbers on waitlists. JH&FMHN are aware of the challenges in recruitment and are investing heavily in telehealth to address service gaps. At the time of writing, JH&FMHN's recruitment information systems did not record information about the number and type of positions unfilled for long periods, for example six months or more.[588] Given the challenges in recruitment, central monitoring of vacancies and length of time to recruit may help map and address service delivery gaps and targeted recruitment or innovative service delivery models for long term vacancies. JH&FMHN should continue to monitor performance data that might be impacted by staff vacancies and where performance targets aren't being met, seek a resolution strategy from management.

586 Information provided by JH&FMHN 2018.

587 Information provided by JH&FMHN 2019 and 2020.

588 Information provided by JH&FMHN.

589 Information provided by JH&FMHN 2019.

Recommendation 39: JH&FMHN and private health providers monitor workforce trends, develop a workforce management strategy, and continue to develop innovative solutions to address service delivery gaps

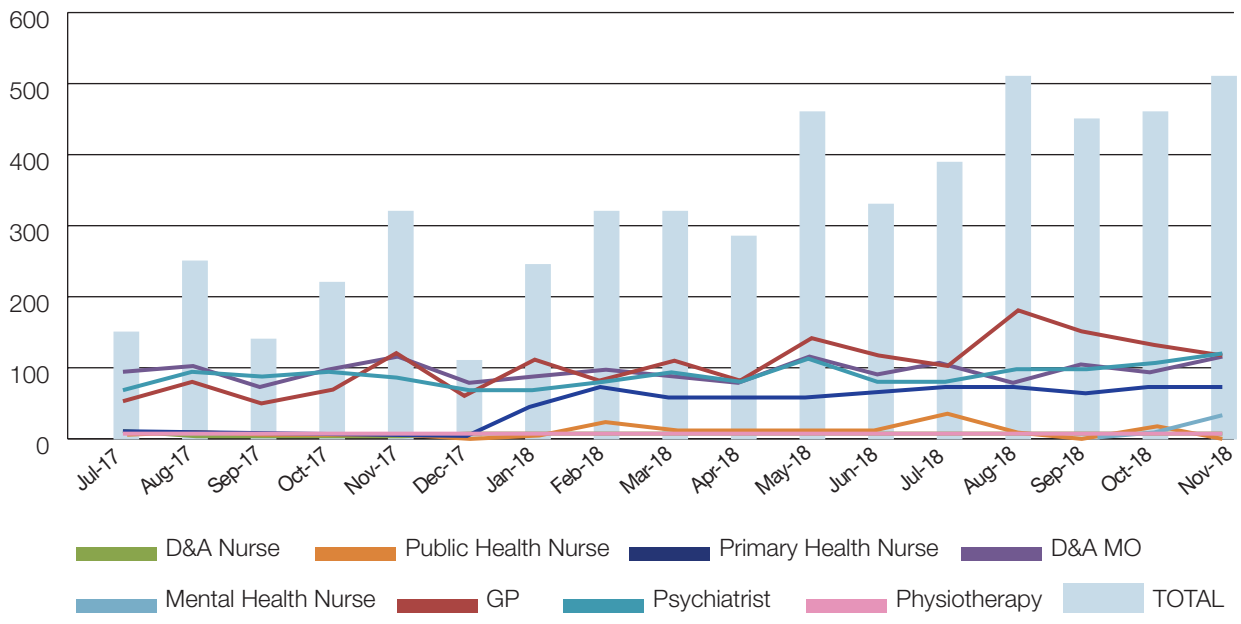
4.3 Access to higher levels of appropriate clinical care

4.3.1 Telehealth

Telehealth improves access to specialist care. Telehealth involves the use of video-link to access remote medical advice and secondary specialist review. Telehealth requires inmates to be escorted to the health centre by custodial staff. Then a RN or other medical officer facilitates and supervises the video link. Telehealth also reduces the need for costly and time-consuming escorts out of correctional centres. This improves the rate of access to health care within correctional centres and may alleviate the pressure on GP and specialist waitlists.[589]

JH&FMHN data on telehealth utilisation demonstrates increasing adoption across the Network.

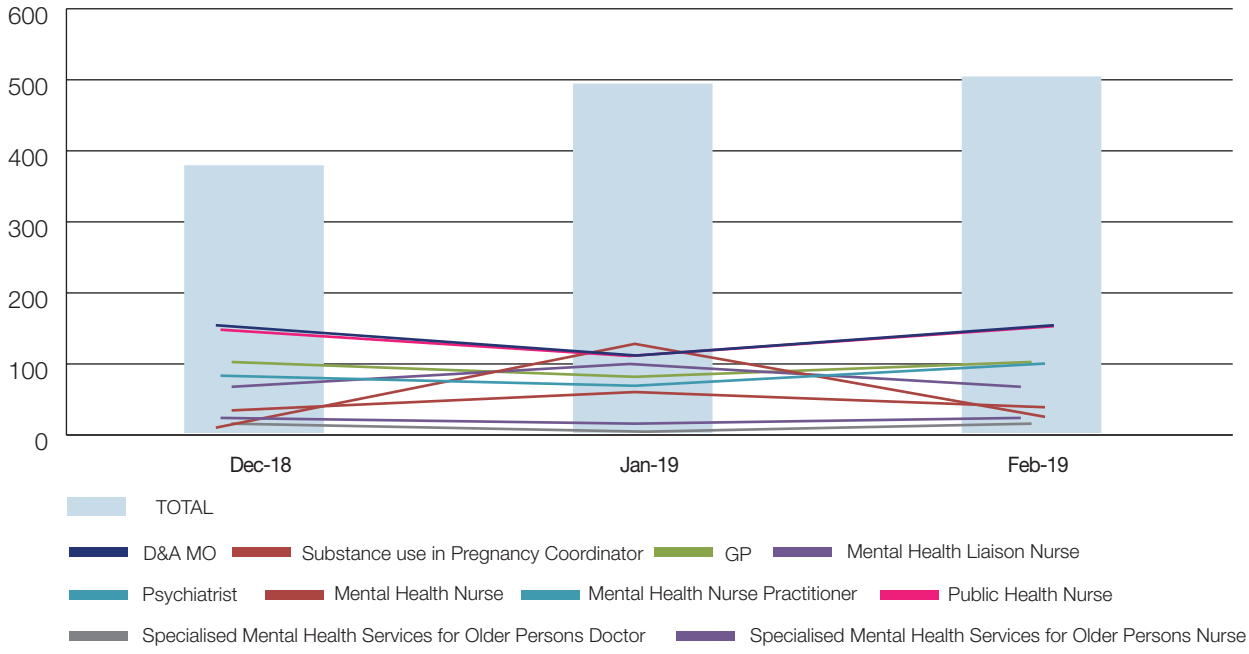
Figure 11: JH&FMHN Telehealth consultations, July 2017 to November 2018[590]



590 Information provided by JH&FMHN 2019.

591 Information provided by JH&FMHN 2019.

Figure 12: JH&FMHN Telehealth consultations, December 2018 – February 2019[591]



It is positive to see use of telehealth for GP clinics. This likely reflects the commencement of the *GP Redesign Project* with a focus on telehealth in order to improve access to targeted and equitable GP services, particularly for inmates in rural areas.[592]

At the time of inspection, JH&FMHN was implementing an enhanced adoption strategy for telehealth.[593] The strategy included piloting specialist outpatient services with Hunter New England, South Eastern Sydney, and Nepean Blue Mountains Local Health Districts.

JH&FMHN report that telehealth is an efficient and effective use of resources, with productivity increases experienced when compared to previous on-site clinics.[594] Occupational therapy and physiotherapy are identified by JH&FMHN as particular areas where telehealth could improve access.[595] Equally however, it is acknowledged that not all health services can be accessed through telehealth, and in some locations, existing infrastructure does not support the use of telehealth and in person health services will still be required.[596]

JH&FMHN has provided telehealth services for many years, however at the time of inspection, where telehealth technology was installed in centres, it was not always being utilised, as the room housing the television screen was often used for face to face consults or other purposes. Where it was being utilised, staff reported the need for paper-based records to be scanned or faxed to the specialist prior to the clinic. In privately operated centres, CSNSW report some instances of clinicians having difficulty accessing the JH&FMHN system.[597] It is recognised that telehealth is likely to become more efficient as it is normalised across the state. During COVID-19 telehealth has been embraced and should become a mainstay of

592 Data for this period is under-reported as it does not include activity generated through the Delivery Mode functionality that went live on the 28 November 2018. Work is underway within JH&FMHN to reconcile all of the Telehealth.

593 Information provided by JH&FMHN 2018.

594 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 61.

595 Information provided by JH&FMHN 2019.

596 Information provided by JH&FMHN 2019.

597 Information provided by CSNSW 4February 2021.

598 Information provided by JH&FMHN 21 February 2021.

custodial health service.

The use of digital cameras in health centres to enable high-resolution pictures of clinically related symptoms is supported by the inspection team. This would allow remote diagnosis of key conditions and reduce the need for transfer to hospital for diagnosis, particularly with dermatological related conditions. One of the correctional centres inspected did not allow JH&FMHN to use a digital camera for security reasons. With appropriate and adequate security protocols in place, this technology could complement telehealth to streamline diagnostics. For example, by capturing images for external specialist review (such as wounds and other clinical presentations) less amenable to a television or phone-based service. JH&FMHN has since implemented a centralised GP and specialist telehealth service and a system to analyse telehealth activity.[598] Increasing the use of telehealth for GP and specialist services should have a significant impact on waitlists, and prisoner movement. To support this service additional health staff may be required, and staff will require training, systems, and targets to assist them to embrace the use of telehealth. Doctors also need to be selected and allocated based on the skills required to deliver an appropriate remote diagnostic service supported by a skilled on-site primary nurse service to ensure appropriate follow up and efficient use of allocated GP hours.

During the 2018-2019 year there was a 335% increase in the number of patients seen by GPs and a 20% reduction in waiting times. More recently during the COVID-19 Pandemic, CSNSW have supported the use of the JUST connect system which is used to book AVL appointments to facilitate medical appointments with inmates. This demonstrates the investment in telehealth technology has delivered a significant return on investment.

Recommendation 40: JH&FMHN and private health providers expand and maximise telehealth to fill service delivery gaps and increase patient access to care

Recommendation 41: CSNSW support JH&FMHN use of AVL suites and digital cameras for telehealth

4.3.2 Medical holds

JH&FMHN must advise CSNSW as soon as practicable if a health officer is of the opinion that an inmate is unfit to travel due to a medical condition.[599] In practice this is referred to as a 'medical hold.' CSNSW policy states that 'JH&FMHN may recommend to CSNSW that an inmate be placed on a medical hold to remain in a particular centre or region for up to three months, after which time the hold will be reviewed.[600] Medical holds ensure access to appropriate levels of care, such as specialist services, monitoring of new patients, and access to 24-hour nursing staff coverage if required. Extensions may occur if ongoing specialist, medical or psychiatric therapy is not available elsewhere, and for which the number of appointments would make the logistics involved unreasonable. The utility of medical holds is particularly important given the high number of inmates moving through the system and transferring between centres.[601]

The inspection team sought data about medical holds for the period July 2017 to November 2018. This information is below at Table 33. The high numbers for the MRRC reflect the high number of patients who are required to stay at MRRC to access acute mental health services in the MHSU or Hamden Units. It is also an indication of the need for increased clinical services at those centres.

599 *Crimes(Administration of Sentences) Regulation 2014* clause 285.

600 COPP 6.1 p7.

601 Refer to Table 6 for 2018 transfer data.

602 Inspector of Custodial Services, *Old and Inside: Managing Aged Offenders in Custody* (Report, September 2015) 38.

Table 33: Number of CSNSW inmates on Justice Health holds by centre, 1 July 2017 to 30 November 2018

Correctional Centre	Number of Inmates
Bathurst Correctional Centre	17
Berrima Correctional Centre	1
Broken Hill Correctional Centre	1
Cessnock Correctional Centre	15
Cooma Correctional Centre	2
Dawn De Loas Correctional Centre	11
Dilwynia Correctional Centre	1
Emu Plains Correctional Centre	1
Goulburn Correctional Centre	4
Grafton Correctional Centre	13
John Morony Correctional Centre	6
Junee Correctional Centre	4
Kariong Correctional Centre	7
Kirkconnell Correctional Centre	2
Lithgow Correctional Centre	1
Long Bay Hospital	5
Macquarie Correctional Centre	1
Mary Wade Correctional Centre	2
Metropolitan Remand and Reception Centre	168
Metropolitan Special Programs Centre	7
Mid North Coast Correctional Centre	7
Parklea Correctional Centre	28
Shortland Correctional Centre	5
Silverwater Womens Correctional Centre	21
South Coast Correctional Centre	53
St Heliers Correctional Centre	2
Wellington Correctional Centre	11

**The statistic was based on all inmates who stayed in CSNSW during the period of 01/07/2017 to 30/11/2018.*
***The inmates on Justice Health holds were identified by checking the health problem alert in the OIMS system.*

Source: CSNSW, provided 6 December 2018.

4.3.3 Aged and frail inmates

Aged and frail inmates face additional challenges in accessing health care, including diminished mobility, cognition, and the level of health services required to treat the comorbidity and clinical complexity which increases with age.[602] Issues for accommodating aged inmates include higher rates of poor physical and mental health, prison infrastructure designed for younger and fitter inmates (for example stairs, bunk beds, long distances to walk between accommodation and service areas), and vulnerability to victimisation[603]

Forrest et al note:

> *Developing a structured daily routine of activities with custodial staff, including time out of the cell, rest, assistance with activities of daily living, access to clinical services and medication administration may minimise the impacts of the parts of the daily prison routine that contribute to tiredness, confusion, incontinence and falls risk.*[604]

Health and custodial staff told the inspection team that providing the additional services, care and specialisation required for an ageing population could generally not be provided in mainstream correctional centres.[605] Additional resources required to meet these needs are associated with significant costs.[606]

Currently the Aged Care Rehabilitation Unit (ACRU) at LBH1 is the only dedicated facility for aged and frail inmates. The unit provides assessment and rehabilitation services for older and/or frail inmates. All referrals to the ACRU are made by the Clinical Director, Aged Care or through the Aged Care Bed Demand Meeting which meets fortnightly.[607] An advising committee comprises a psychogeriatrician, geriatrician and a clinical nurse consultant.[608] All CSNSW staff employed at the ACRU receive training from JH&FMHN in dementia, behaviours of dementia patients, and mental health awareness.[609]

Inmates admitted to the unit include:

- Those with a decreased level of day-to-day functioning requiring comprehensive physical and cognitive assessment
- Inmates with chronic complex conditions that cannot be appropriately managed elsewhere in the custodial environment
- Inmates requiring long term accommodation due to increasing frailty and requiring assistance with activities of daily living.[610]

There is no paper-based waitlist for this facility, however for the six month period July – December 2018 there were between one to three inmates awaiting admission.[611] The average length of stay in the ACRU for 2017-2018 was 303 days.[612] This suggests that the unit is being used as a long term placement option rather than a stabilisation measure. It may also reflect the limited step-down options in the system for aged

603 Baidawi et al., 2011; Trotter & Baidawi, 2015; Turner & Trotter, 2010.

604 Gary Forrest, Susan Baidawi, Tanya Atkinson, Helen Small and Maree Bernoth, Previously Unrecognised Issues: Managing the Health of an Ageing Prison and Homeless Population, in Bernoth, Maree, and Denise Winkler, 'Healthy Ageing and Aged Care', 2016, p225.

605 Interviews with staff 2018.

606 BOCSAR Changing age profile of NSW offenders Efty Stavrou Issue paper no.123 March 2017

607 Information provided by JH&FMHN July 2019.

608 Information provided by JH&FMHN October 2018.

609 Information provided by CSNSW September 2017

610 Justice Health & Forensic Mental Health Network, policy, *Admission & Assessment: Aged Care & Rehabilitation Unit, Long Bay Hospital,* policy issued July 2014, p. 2.

611 Information provided by JH&FMHN 2018.

612 Information provided by JH&FMHN 2018.

613 Information provided by JH&FMHN July 2018.

and debilitated inmates. This is significant considering reports that demand for these beds is increasing.[613] The increase in the numbers of aged inmates in NSW correctional facilities is provided by Table 2.

In 2015, the ICS recommended that CSNSW, in collaboration with JH&FMHN, create accommodation for aged and infirm inmates in the metropolitan area, through a new CSNSW facility or acquiring an existing aged-care facility in the community. The same report recommended that JH&FMHN review the current levels of service provision against the projected demand for aged-care services. In 2017, JH&FMHN announced a qualitative study to more clearly identify the needs of aged inmates, and the impact of the custodial environment upon them.[614] JH&FMHN advised the ICS in June 2018 that they 'require feasibility and impact assessments' in order to implement this recommendation.

Age and frailty should not be a barrier to accessing adequate healthcare. Innovative responses from JH&FMHN, CSNSW and private providers are required to meet the needs of this population. Since the inspection, GEO has developed a specific policy relating to caring for older patients.[615] Agencies should be resourced such that they are able to respond to this challenge, and relationships with private providers with expertise in providing aged care services should be explored. CSNSW reported that their strategy for elderly and aging inmates was under development.[616]

Given the increase in the number of aged inmates between 2015 and 2019, additional beds for aged inmates are required in the system. This is to provide an appropriate physical environment for ease of basic living such as ambulating and showering, and adequate levels of access to health services. In August 2020 CSNSW announced the creation of an additional 100 beds for aged inmates in metropolitan Sydney. This will go some way to addressing the need.[617]

Recommendation 42: CSNSW with JH&FMHN create sufficient aged care beds in the Sydney metropolitan area with regard to an appropriate physical environment for ease of basic living such as ambulating and showering, and adequate levels of access to health services.

4.3.4 Terminal illness and end of life pathways

JH&FMHN policy states that

> *patients nearing the end of their life due to disease progression should receive the necessary level of care, such as that which can be provided at Long Bay Hospital or, where necessary at an external hospital.*[618]

A palliative care team services the medical sub-acute unit of LBH1 and the Secure Annex of Prince of Wales Hospital, Randwick. The early involvement of the team is to provide pain relief. Later involvement is around the end of life pathway. It is important to allow inmates to die with dignity. JH&FMHN and Prince of Wales Hospital consider an inmate's preference regarding location for their end of life pathway. End of life pathways include decisions around advanced care planning including, no CPR orders and advanced care directives.[619] The inspection team heard from JH&FMHN staff that inmates tend to choose LBH1 rather than the Prince

614 Justice Health and Forensic Mental Health Network, *Year in Review 2016-2017* (Department of Health (NSW), December 2017) 76.

615 HS2.18A *Caring for Older Patients and Those with a Disability* and a supplementary *Policy Guide for Health Services Staff,* Information provided by GEO 21 January 2021.

616 Information provided by CSNSW 2018.

617 Information provided by CSNSW August 2020.

618 JH&FMHN policy 1.174 p 1.

619 JH&FMHN policy 1.174 p 1.

620 Interviews with staff 2018.

of Wales Hospital for end of life care.[620] It is also possible for some inmates who are terminally ill to apply for parole.[621] Although an inmate may not be eligible for parole due to the nature of an inmate's offences, eligible inmates should be made aware of their ability to make a parole application to be released from custody before their death.[622] All natural and unnatural deaths in custody must be referred to the Coroner which may result in recommendations to JH&FNHN or CSNSW.[623]

Recommendation 43: CSNSW ensure eligible inmates who are terminally ill are aware of the ability to apply for parole.

4.4 Effective and efficient management of clinical information

4.4.1 Clinical handover

JH&FMHN has introduced a standard daily clinical handover process which occurs between nursing shifts. The process includes documenting patients of concern and patients of interest. Patients of concern include those who have been transferred out to hospital, patients remaining in hospital as well as patients who may be in the medical observation cells. Patients with conditions requiring frequent observations to be actioned at the clinic will also be highlighted. Patients of interest include those with less acute issues but likely to need review or prioritisation for primary health lists.

In some centres, clinical handover was also utilised as a clinical staff development process. Positive approaches included the NUM or HSM participating in the handover process and using the opportunity to discuss the presenting issue of a specific case, and challenge staff to consider additional underlying issues which could be clinically relevant. The process also allowed nursing staff to present to their peers in relation to a patient of interest with the peer review process providing a level of positive clinical supervision. The NUM was also able to ask for a more urgent review process when their expert review and knowledge suggested a patient's condition was at risk of deteriorating. Prioritised review and access to the GP would then be actioned.

4.4.2 Records

The Health Records and Information Privacy Act 2002 require JH&FMHN to maintain proper medical records for each patient. This includes the physical or mental health of an individual.[624]

A physical patient record file contains detailed patient clinical notes, specialist and diagnostic reports, medication charts and a copy of the Reception Assessment. A paper copy of the file is retained within the health centre at the prison where the inmate is residing. Physical medication charts are kept in the clinic medication room to assist with daily/weekly and self-administered medication administration.

If an inmate is transferred to another centre, the physical file is updated with a note of any urgent handover issues for the next clinic. The file is then sealed within an opaque locked bag and the inmate's HPNF is affixed to the outside of the transfer bag. In this manner patient confidentiality is maintained while providing any urgent information a correctional officer may require during the transfer.

621 *Crimes (Administration of Sentences) Act 1999* (NSW) s 160(1); Corrective Services NSW, Compassionate Release (Custodial Operations Policy and Procedures, Policy 23.2, 16 December 2017), 9, pt 5.1

622 *Crimes (Administration of Sentences) Act 1999* (NSW) s 160(1)and (4); Corrective Services NSW, Compassionate Release (Custodial Operations Policy and Procedures, Policy 23.2, 16 December 2017), 9, pt5.1

623 *Coroners Act 2009* s 23(1)(d)) and s 35(1)(a).

624 See *Health Records and Information Privacy Act 2002, definitions of 'health information'.* See also *Crimes (Administration of Sentences) Regulation 2014* clause 288.

625 Interviews with staff 2018.

At the receiving centre, the file is reviewed by the receiving RN who transfers any outstanding appointments to the receiving health centres' waitlists and any urgent medications or issues attended.

Maintaining and transferring files is time consuming, repetitive and there were reports by some reception staff of occasions when the physical file is separated from the inmate/patient on transfer.[625] This may be that the file was left behind or had not been handed over to the new centre on transfer. In the absence of a physical file, electronic clinical records assist in the management of urgent conditions, however the challenge of prescribing and managing medication remains.

Significant clinical risk will be mitigated, and clinical efficiencies delivered by the rapid implementation of the electronic medication management system.

4.4.3 Clinical information systems

The ability to record and communicate clinical information between health professionals is essential for good healthcare. Recording and communicating clinical information within JH&FHMHN occurs through various methods. Paper-based physical clinical record is the primary mechanism. The file consists of paper-based assessment forms, contemporaneous notes of medical officers, nursing and any allied health clinical interventions and interactions, pertinent clinical history, medication administration charts, specialist reports, diagnostic reports and pathology records.

Clinical information from the community is requested by nursing and health administrative staff using the ROI form. The required clinical information (for example prescribed medication) is documented and the inmate provides consent for its release to JH&FMHN. This manual process is resource intensive and relies on the timely processing of the request by the community-based health provider.

The paper clinical record travels in a secure 'pouch' when the inmate is transferred between locations or when the inmate may be sent to a secondary or tertiary health service for specialist review and intervention.

JH&FMHN have implemented a number of electronic health systems assisting communication of clinical information over the past two decades. These have included:

- the Justice Health Electronic Health System (JHeHS) - which allows recording of key clinical information and clinical assessments (such as the reception assessment)
- PAS allows for the creation and tracking of planned appointments and waiting lists (e.g. primary health nurse clinic).
- JHeHS pathology ordering system has greatly improved transparency and communication of pathology information. The ordering of other diagnostic tests through this functionality was being implemented throughout the inspection period.
- The Community Health Information Management Enterprise (CHIME) manages information related to outpatient mental health services. It records mental health clinical assessment information (e.g. MHOAT assessments as are standardly recorded in community mental health teams across the state), records of clinical interactions by mental health teams, and is used for statistical data management purposes. The same system is used by the majority of Local Health Districts for community mental health which allows JH&FMHN review of some records from other community mental health teams.-
- The Information System for Oral Health (ISOH) manages waiting lists for public oral health services in NSW LHDs. The system also allows prioritisation and management of waiting lists for dental services

626 Information provided by GEO 21 February 2021.

across all JH&FMHN adult correctional centres. ISOH, however, is not a clinical record although it can record some minimal notes regarding interaction and interventions with the dental patient. Dental waiting lists are now managed on the Titanium electronic oral health record system (Titanium).

- Picture Archiving and Communication Systems (PACS) and Radiology Information System (RIS) provide a repository of radiology images for JH&FMHN health centres with in-house radiology service. The RIS does not contain radiological images undertaken by non -JH&FMHN services.

Despite the implementation of the above systems, issues remain regarding the efficient management of patient related clinical information. For example, Junee and other private correctional centres are not networked onto the ISOH, Titanium or PACS/RIS information systems.[626] Workarounds have been developed but these are often labour-intensive and mean that an inmate arriving at a private centre may be not be placed appropriately on the receiving centre's waiting list system. Further, ISOH is a legacy computer system and does not contain a full dental electronic record. Given the size and complexity of the oral service and patient demand across the NSW correctional system, prioritisation of the Titanium electronics record system should occur. Private correctional centres/health providers should be included within this rollout. Similarly, consistency in radiology imaging and information systems between public and private centres is recommended for efficient and accurate continuity of care and better outcomes for patients.

Recommendation 44: JH&FMHN include GEO and other private health providers within the implementation of Titanium, PACS/RIS, JHeHS functionality upgrades and any future electronic information system upgrades

The electronic health record systems used by JH&FMHN do not interface with equivalent systems used in LHDs. This means that electronic discharge summaries from treating hospitals for JH&FMHN patients are not easily uploaded into JHeHS. Use and review of MyHealth records in prisons may improve continuity and timeliness of care. As the MyHealth record is an 'opt-out' system-it is-possible that inmates may enter the correctional system with information contained within standard community electronic health records. Checking MyHealth records upon reception to custody could allow a confirmation process for medications prescribed in an individual's clinical history. It could also provide access to discharge summaries and records in relation to previous clinical care from the public acute hospital system and JH&FMHN.

The system may also provide opportunities for clinical information to follow the individual inmate post-release with their consent. It is acknowledged that the delivery of clinical care within the correctional environment may not be something the patient would like recorded in MyHealth.

Recommendation 45: JH&FMHN should develop procedures in relation to use and review of the My Health record.

The transfer of clinical information in an efficient and effective manner is vital for high quality and safe clinical care. The current JH&FMHN electronic record systems do not provide a fully integrated electronic health record.

The absence of an electronic medication management system leads to huge burdens on medical and nursing staff in the prescribing, administration, recording and management of medication. The inclusion of medication management systems in any electronic record is vital to bringing efficiencies to JH&FMHN. NSW Health should support JH&FMHN to implement an appropriate electronic medication management system which includes electronic prescribing. JH&FMHN are working on the implementation of an eMeds solution

627 Information provided by JH& FMHN October 2018.

by the end of 2021.[627]

The inspection team also observed the impact in time and work effort in providing access to the clinical record in paper form. The impact of this work is particularly seen in relation to tele-psychiatry. Nursing staff had to photocopy and fax large parts of the paper-based record to the location where the psychiatrist would be delivering the tele-psychiatry service. The faxed record was then reviewed by the psychiatrist, the clinical assessment or review is then conducted, and a notation by the psychiatrist would be faxed back for the physical paper-based record. Inefficiencies in the tele-psychiatry service due to this duplication of clinical recording would be remedied with the introduction of an integrated electronic medical record, available remotely, which would maximise the benefit of all telehealth services.

New South Wales Health is migrating to a single integrated health record, commencing in 2019 and to be fully implemented by 2021. The clinical and business process efficiencies that such an initiative will deliver for JH&FMHN are significant and implementation should be prioritised.

Recommendation 46: JH&FMHN and NSW Health support the plan to migrate to a single integrated e-health record, including electronic medication management and prescribing in line with current scheduled timeframes.

4.5 Continuity of care

Good continuity of care improves health and reduces reoffending. The period immediately after incarceration is a very high-risk time for newly released inmates, who often require pre-release and ongoing post-release support in a range of areas including health, mental health and drug-and alcohol. Preparation for the post-release period should commence while an inmate is still incarcerated. The public health imperative of adequate preparation and post-release support is significant given that the ex-prisoner population in Australia is approximately 1.8% of the Australian population. [628]

Consideration of post-release and community services is beyond the scope of this report. However, it is noted that the quality, continuity, and cultural appropriateness of care provided to former prisoners upon release is critical.[629] Ex-prisoners have been found to have high rates of mental illness, high rates of homelessness post release, and high rates of recidivism (Baillargeon et al. 2010).[630]

JH&FMHN policy identifies that 'a smooth patient transition from custody to the community is essential to reduce health risk and ensure transfer and continuity of care post-release'.[631] JH&FMHN's *Planning and Transfer of Care Policy* guides release planning, including for patients with complex needs, and unplanned releases.

JH&FMHN provides a range of services support to people upon release.[632] JH&FMHN has a centralised release planning and support system – the Integrated Care Service. Patient priority is based on the complexity of health need additional services the person may need post-release. Mental health, drug and alcohol, and complex chronic diseases are eligible for this post-release support service. Telephone access to the Integrated Care Service is available upon release for people with a chronic disease requiring

628 Megan Carroll1 , Matthew J Spittal1 , Anna R Kemp-Casey2,3 , Nicholas G Lennox4, David B Preen5 , Georgina Sutherland1 , Stuart A Kinner1,6,7 High rates of general practice attendance by former prisoners: a prospective cohort study Medical Journal of Australia 207 (2) 17 July 2017.

629 Megan Carroll, Matthew J Spittal, Anna R Kemp-Casey, Nicholas G Lennox, David B Preen, Georgina Sutherland, Stuart A Kinner, *High rates of general practice attendance by former prisoners: A prospective cohort study,* MJA 207 (2) July 2017

630 Report for NSW Mental Health Commission – Mental Health and Homelessness – 2013 p 22

631 JH&FMHN policy 1.141 *Release Planning and Transfer of Care Policy – Adult Ambulatory Setting*

632 https://www.justicehealth.nsw.gov.au/patient-support.

633 JH&FMHN Website Information for released patients https://www.justicehealth.nsw.gov.au/patient-support.

assistance with community medical appointments.[633]

Since the inspection Junee Correctional Centre has commenced providing Naloxone Inhalers to inmate patients on discharge, as a means of reducing the risk of narcotic overdose after release.[634]

The JH&FMHN Connections Program coordinates post-release access to health and welfare services in the community for individuals with drug and alcohol concerns, and provides transition and reintegration support.[635] Connections is available in public correctional centres however privately-run correctional centres do not have access to the program.[636] JH&FMHN report that demand for this program always exceeds capacity. The number of inmates supported by the Connections program in the 2016-2017 period was 778.[637] Over the 2017-2018 period, 738 patients were supported.[638] The Connections program has a total of 23.6 FTE. This is an inadequate amount of resource to coordinate care for the most complex of cases, let alone allowing for a smooth transition to the community for clients with medical, mental health and other clinical follow up requirements.

Transfer of data and clinical information on care provided should be at least to the minimum standard as occurs within the community. This is particularly important for Aboriginal inmates and those with complex or chronic conditions. A 'discharge summary' from the Health Service providing care to the patient's GP should be a minimum requirement. Connections is currently being externally evaluated.[639]

The inspection team did see a demonstration of good practice in relation to transferring inmates back to the community at John Morony Correctional Centre. Significant coordination between correctional services and JH&FMHN occurs whenever an offender is likely or is planned for release. Processes have been developed to ensure inmates are reviewed by the clinic and pre-discharge planning occurs if the person is granted bail during video court. The active participation and collaboration between correctional services and JH&FMHN staff to ensure that no person left JMCC without appropriate planning for continuing health services is to be commended.

Recommendation 47: JH&FMHN and the private health providers support discharge planning for selected Aboriginal and complex primary care level patients.

JH&FMHN identifies that '…partnerships with the criminal justice system and health services in the community remain critical to improving the health status of the inmate population in NSW.'[640]

Discharge planning and transfer of care back to the community is a challenge given the busy correctional system, the number of individuals moving through the system, and the separate organisations responsible for ongoing care. Post release care in the community for most will be delivered under a primary care model by GPs funded by the Commonwealth government through MBS and medication through the PBS. Access to the Medicare system is a right for all Australians. The challenge of accessing Medicare during imprisonment and in release planning creates barriers to continuity of care. There is a perception that a

634 Information provided by GEO 21 January 2021.

635 Justice Health and Forensic Mental Health Network, *Year in Review 2016-2017* (Department of Health (NSW), December 2017) 56.

636 Information provided by JH&FMHN 2018.

637 Justice Health and Forensic Mental Health Network, *Year in Review 2016-2017* (Department of Health (NSW), December 2017) 56.

638 Information provided by JH&FMHN 2018.

639 Information provided by CSNSW 4 February 2021.

640 NPHS report p 12; In March of 2017, the Australian Medical Association, the Royal Australian and New Zealand College of Psychiatrists, and the Public Health Association of Australia, called for Minister for Health to call for an end to the exclusion of prisoners from Medicare and the PBS and cited that the Health Minister's power to waive the Medicare exclusion was explicitly included in s 19(2) of the *Health Insurance Act* so that governments could make amendments if the exclusion was deemed to cause disadvantage, see <https://ama.com.au/ausmed/prisoners-could-get-medicare-without-heavy-taxpayer-burden>.

641 Information provided by GEO 21 January 2021.

person loses access to Medicare during a period of incarceration. The actual situation is possibly more complex with the Commonwealth government seeing the responsibility of health services for prisoners being a state responsibility. This manifests in confusion over the appropriate time to re-engage with the Medicare/ MBS system.

Previous efforts to resolve these issues at a national level have been unsuccessful. However, given the support for reducing incarceration rates for Aboriginal and Torres Strait Islander people as part of the Closing The Gap initiative, it should be revisited. Aboriginal community controlled health services are a Commonwealth responsibility and is not able to be provided by the state.

Recommendation 48: Consideration should be given to ongoing advocacy to allow inmate access to Medicare particularly in the area of Aboriginal health services and complex primary care level patients.

4.6 Performance monitoring frameworks

Consistent performance monitoring frameworks drive service improvement. Good health centre access and positive collaboration between custodial and health staff was observed at centres with performance monitoring mechanisms such as KPIs and contracts to drive continuous improvement. Health service delivery appeared strong at John Morony CC and a genuine culture of collaboration was observed between custodial and health staff. Inmates reported respectful and responsive relationships with health and custodial staff. Good levels of access were also observed at Junee CC, as was a collegiate relationship between health and custodial staff.

Table 34 below sets out a comparison of the health related KPIs at NSW correctional centres at the time of inspection and details KPIs now in existence. At John Morony CC, health related KPIs drive service and contract compliance. In NSW public correctional centres, health KPIs exist in relation to NSW Health's state priorities. At the time of inspection Junee CC, did not have KPIs related to health service delivery. Under the new Management Agreement and performance regime, Junee Correctional Centre, have seven new KPIs that directly relate to health service delivery.[641]

641 Information provided by JH&FMHN, 21 February 2021.

Table 34: Health Service KPIs by Service Provider

John Morony CC	JH&FMHN	Junee CC (GEO)
• Numbers of eligible patients with chronic health care plans • Timely provision of health service to high priority patients • Numbers eligible patients with health discharge plans • Early detection of BBVs/STIs • Immunisations • Health-related incident reporting • Health screening assessments occurring within 24 hours	• Targets for continuity of care for OST • Monitoring of patients with complex D&A needs • Numbers of Aboriginal people accessing the Aboriginal chronic care plan. • Population health vaccine target	• There were no health service KPIs at the time of inspection. Junee CC now has seven KPIs as per below • Numbers of eligible patients with chronic health care plans • Timely provision of health service to high priority patients • Numbers eligible patients with health discharge plans • Early detection of BBVs/STIs and Immunisations • Health-related incident reporting • Health screening assessments occurring within 24 hours • Drug and alcohol referral for pregnant women

New contracts between CSNSW and private health service providers for Parklea Correctional Centre, Junee Correctional Centre and Clarence Correctional Centre are now subject to the same KPIs as those at John Morony CC. This is designed to ensure the delivery model for inmate health is consistent across Junee, John Morony, Parklea and Clarence CCs. The delivery of health services by private or sub-contracted service providers is monitored by JH&FMHN pursuant to a governance and monitoring framework that was developed in 2018. It may therefore be timely to review the governance and monitoring framework.

Future planning should bring consistent KPIs across public and private health service providers to provide a level of benchmarking and support continuous improvement across the system. JH&FMHN have advised that they are in the process of developing a KPI dashboard according to the KPIs used for John Morony CC. It is currently limited to privately operated facilities and will be undergoing data validation. Once ready, the dashboard will have the capability to extract data for all health centres to assist with the monitoring and management of KPIs.[642]

The goal of improved service delivery and performance monitoring is 'a seamless and integrated healthcare experience for patients moving between public and private healthcare providers.'[643]

Recommendation 49: JH&FMHN and CSNSW consider consistent KPIs for health service delivery across public and private health service providers.

646 Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 69.

644 JH&FMHN expenses budget as per Service Agreement with the Ministry of Health, provided by CSNSW adult custodial population from monthly average of BOCSAR custody tables.

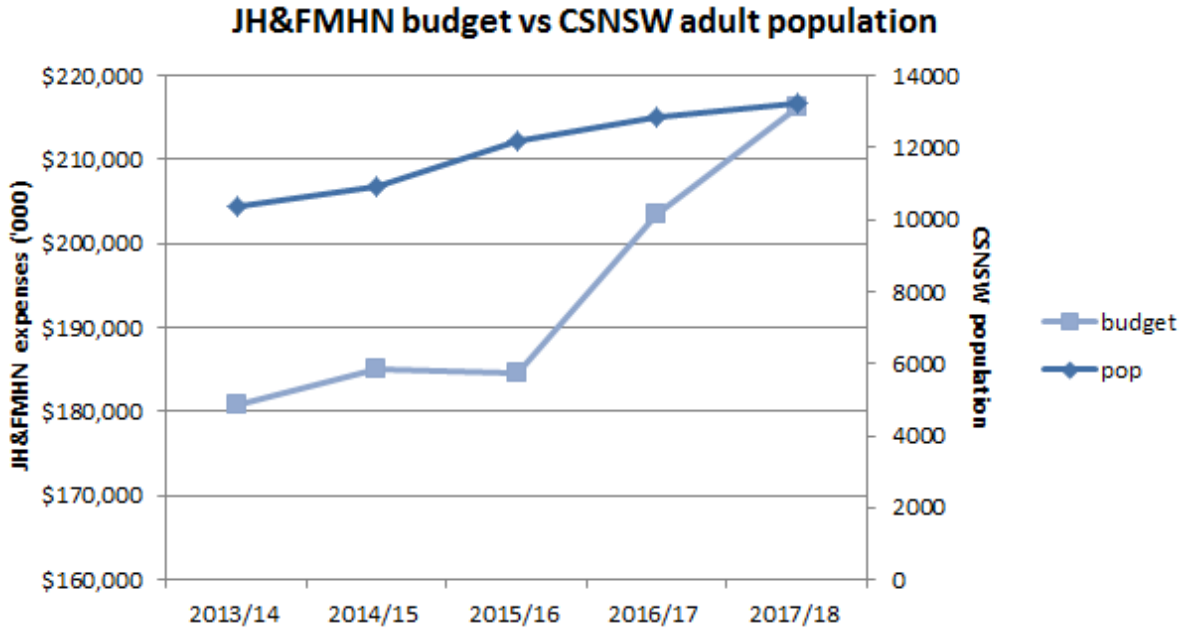
4.7 Resourcing the system

Evidence and findings of this inspection suggest that resourcing has not kept pace with demand. Table 35 below shows the increase in the NSW custodial population relative to JH&FMHN expenses over a five-year period.[644]

Table 35: NSW Adult Custodial Population and JH&FMHN Budget Expenses During the Period FY2013-14 to FY2017-18

Financial Year	NSW adult custodial population	JH&FMHN budget expenses ('000)
2013/14	10370	$180,728
2014/15	10939	$185,179
2015/16	12200	$184,485
2016/17	12826	$203,527
2017/18	13254	$216,219
5-year % increase	**27.8%**	**19.6%**

Figure 13: JH&FMHN Budget vs CSNSW Adult Population FY2013-14 to FY2017-18



It is challenging for JH&FMHN to meet the demand for services. Service delivery needs to be regularly reviewed to ensure efficiency and effectiveness. JH&FMHN does very well to adapt and respond to the changing environment. However, JH&FMHN need to be appropriately resourced and have a robust and sustainable funding model to provide their model of offender health.

645 Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) vi, 49; The Royal Australian College of General Practitioners, *Standards for Health Services in Australian Prisons* (1st ed, April 2011) 2-3 ; Justice Health and Forensic Mental Health Network, *Year in Review 2016*-17 (Department of Health (NSW), December 2017) 14.

The JH&FMHN Board should continue to monitor performance data and reports provided by management indicating progress against the Network's Strategic Directions to ensure appropriate Network governance, budget allocation and risk management. Specific areas of need with significant resourcing implications addressed in the report are mental health, Aboriginal health, and aged care. The Board should work with the Network Executive to determine an appropriate mitigation strategy such as additional funding or comprehensive service review.

Recommendation 50: JH&FMHN are resourced commensurate to size of the prison population, with regard to wage price index and health price index.

5. Conclusion

The health needs of the NSW prison population are significant and complex. Incarceration is an opportunity to meet the needs of this vulnerable population, the majority of whom return to the community after relatively short periods. Therefore, there is a significant public health imperative to ensure health care is available and accessible in custody to a standard comparable to community health care.

The health services available in custody are generally comparable with community standards however timely and coordinated access to health care is an ongoing challenge. For the most part this is due to the securitised nature of the custodial environment. However, JH&FMHN and private contracted health service provider staffing issues, CSNSW operational regimes and a lack of coordination between JH&FMHN, private health providers and CSNSW also impact access to health services.

The Inspection found that the model of offender health provided by JH&FMHN is comprehensive and is supported by good clinical governance and a continuous improvement approach. However, there is a general under-resourcing of the correctional health system because demand outstrips supply. This is largely due to the increasing prisoner population in NSW, and the health profile of the prisoner population with high levels of chronic illness, mental health problems, post-traumatic stress, substance use issues and communicable disease, dual diagnoses of mental health issues and physical or other health problems.[645]

It is therefore timely to review the model of custodial health care to ensure the model of care is able to deliver health care to a standard comparable with the community.

It's time to close the gap and provide continuity of primary health care for Aboriginal people in prison. This will further enable governments to deliver on their agreed commitments to achieving the Close The Gap targets - in particular to improving the health outcomes for Aboriginal and Torres Strait Islander people in custody, and contributing to reducing that cohort's recidivism rates. Collaborative, ongoing and systemic advocacy by NSW Government and other stakeholders directed at access to the Medicare Benefit Schedule for this high priority population is an important aspect to achieving this goal.

Increased funding for correctional centre-based health services, and improved access to those services, is required. However, there is also a need for support of and increased funding for innovative models for transition care and support for high risk populations. These will include those with significant mental health issues, a history of alcohol and other drug use, chronic disease, and Aboriginal and Torres Strait Islander people returning to the community.

646 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), GA Res 70/175, UN Doc A/RES/ 54/254 (8 January 2016, adopted 17 December 2015) rule 24.

Appendices

Legislation

Crimes (Administration of Sentences) Act 1999	
41C. Transfers to and from juvenile correctional centres	(6) Such an order may not be made without prior consultation between the Commissioner and the Chief Executive Officer, Justice Health.
73. Compulsory medical treatment	(1) A medical practitioner (whether that practitioner is a medical officer or not) may carry out medical treatment on an inmate without the inmate's consent if the Chief Executive Officer, Justice Health is of the opinion, having taken into account the cultural background and religious views of the inmate, that it is necessary to do so in order to save the inmate's life or to prevent serious damage to the inmate's health. (2) Medical treatment carried out on an inmate under this section is, for all purposes, taken to have been carried out with the inmate's consent. (3) Nothing in this section relieves a medical practitioner from liability in respect of the carrying out of medical treatment on an inmate, being a liability to which the medical practitioner would have been subject had the treatment been carried out with the inmate's consent. (4) If the Chief Executive Officer, Justice Health is not a medical practitioner, the reference to the Chief Executive Officer, Justice Health in subsection (1) is taken to be a reference to a person, designated by the Chief Executive Officer for the purposes of that subsection, who is a medical practitioner.
106F. Compulsory drug treatment personal plans	(3) The Commissioner, when preparing a compulsory drug treatment personal plan, must consult the Chief Executive Officer, Justice Health or the Chief Executive Officer's delegate.
106G. Variation of conditions of personal plan	(3) The Commissioner, when preparing a variation to a compulsory drug treatment personal plan, must consult the Chief Executive Officer, Justice Health or the Chief Executive Officer's delegate.
106U. Formal assessment by Director	(2) An assessment report under this section is to be prepared in consultation with the Chief Executive Officer, Justice Health and the Drug Court.

154A. Serious offenders the subject of non-release recommendations	(1) Section 143 does not require the Parole Authority to give preliminary consideration as to whether or not a serious offender the subject of a non-release recommendation should be released on parole unless an application for that purpose is made to the Parole Authority by or on behalf of the offender. (2) An application under this section must be lodged with the Secretary of the Parole Authority. (3) After considering the application, the Parole Authority may make an order directing the release of the offender on parole if, and only if, the Parole Authority— (a) is satisfied (on the basis of a report prepared by the Chief Executive Officer, Justice Health) that the offender— (i) is in imminent danger of dying, or is incapacitated to the extent that he or she no longer has the physical ability to do harm to any person, and (ii) has demonstrated that he or she does not pose a risk to the community, and (b) is further satisfied that, because of those circumstances, the making of such an order is justified.
161A. Provision of information by health service providers	(1) It is the duty of a health service provider involved in the provision of services to or in respect of an offender to provide the following information on request by a community corrections officer— (a) whether or not the offender has attended a program orany appointment in which the health service provider is involved that is required by a condition of the offender's parole order or by a direction of a community corrections officer, (b) whether or not the offender has participated in any other activity in which the health service provider is involved as required by a condition of the offender's parole order or by a direction of a community corrections officer. (2) Nothing in this section requires a health service provider to provide any information relating to events that occurred during any treatment, program or activity in which the offender participated. (3) The offender is taken to have authorised the provision of information in accordance with this section by the health service provider. (4) The provision of information under this section by a health service provider does not constitute— (a) a contravention of the Health Records and Information Privacy Act 2002 orthe Privacy and Personal Information Protection Act 1998, or (b) a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct. (5) In this section— health service provider means— (a) a health service provider within the meaning of the Health Records and Information Privacy Act 2002, or an individual who provides a health service within the meaning of that Act.

236A. Functions of Justice Health	Justice Health, in addition to any other functions conferred on it by or under this or any other Act or law, has the following functions— (a) to provide health services to offenders and other persons in custody within the meaning of section 249, (b) to monitor the provision of health services in managed correctional centres, (c) to prevent the spread of infectious diseases in, or in relation to, correctional centres, (d) to keep medical records of offenders and other persons in custody within the meaning of section 249, (e) to provide advice to the Commissioner on the diet, exercise, clothing, capacity to work and general hygiene of inmates.
236B. CEO, Justice Health, to have access to correctional centres, offenders and medical records	For the purpose of ensuring that the provisions of this Act and the regulations (in so far as they relate to the functions of Justice Health) are being complied with at a correctional centre, the Chief Executive Officer, Justice Health, is to have free and unfettered access at all times to all parts of the correctional centre, to all medical records held at the correctional centre and to all offenders held in custody in the correctional centre.
236C. Appointment of medical officers	(1) The Chief Executive Officer, Justice Health, may appoint one or more registered medical practitioners as medical officers for a correctional centre. (2) A registered medical practitioner may be appointed as a medical officer for one or more correctional centres. (3) A medical officer is subject to the direction and control of the Chief Executive Officer, Justice Health. (4) A medical officer for a correctional centre is to attend the correctional centre as regularly and frequently as is necessary to comply with the medical officer's statutory obligations. (5) The Chief Executive Officer, Justice Health is to keep such statistical records, and furnish to the Commissioner such returns, as the Commissioner may direct in relation to health services provided to inmates. (6) A person who held office as a medical officer for a correctional centre immediately before the commencement of this section is taken to hold office pursuant to an appointment under this section, and the appointment may be suspended or revoked accordingly
236D. Delegation of functions of CEO, Justice Health	(1) The Chief Executive Officer, Justice Health, may delegate to any person any of the Chief Executive Officer's functions under this Act, other than this power of delegation. Subsection (1) does not enable the Chief Executive Officer, Justice Health to delegate the right of free and unfettered access conferred on the Chief Executive Officer by sections 236B and 244

244. CEO, Justice Health, to have access to correctional centres, offenders and medical records	(1) For the purpose of ensuring that the provisions of this Act and the regulations (in so far as they relate to medical, surgical or dental treatment or to the health of offenders) are being complied with at a managed correctional centre, the Chief Executive Officer, Justice Health, is to have free and unfettered access at all times to all parts of the correctional centre, to all medical records held at the correctional centre and to all offenders held in custody in the correctional centre. (2) Nothing in this section— (a) affects any power conferred on the Chief Executive Officer, Justice Health, with respect to any correctional centre, or (b) affects any duty of a management company, submanagement company or correctional centre medical officer under this Act, the regulations or any agreement.

Crimes (Administration of Sentences) Regulation 2014	
54. Dental and optical treatment and artificial medical appliances	Dental treatment, optical treatment and hearing aids and other artificial medical appliances are to be supplied to inmates in the way and to the extent the Chief Executive, Justice Health and Forensic Mental Health Network, determines
162. Supply of test results to Justice Health and Forensic Health Network	The Commissioner may provide results of positive tests of drug test samples to— (a) the Chief Executive, Justice Health and Forensic Mental Health Network, and (b) in the case of tests on serious offenders, the Review Council.
258. Hospitals	For the purposes of Division 5 of Part 11 of the Act, the following premises, institutions or establishments are prescribed as a hospital— any clinic or other premises operated by Justice Health and Forensic Mental Health Network, any premises, institution or establishment that is a hospital for the purposes of Division 4 of Part 2 of Schedule 3 to the Road Transport Act 2013.
284. Examination of inmates	(1) inmate is to be examined by a prescribed health officer as soon as practicable after being received into a correctional centre. Without limiting subclause (2), a prescribed health officer may at any time carry out an examination of an inmate (but only with the consent of the inmate) if of the opinion that it is necessary for the examination to be carried out.

285. Inmates' risk to self or others	(a) As soon as practicable after forming an opinion— that the mental or physical condition of an inmate constitutes a risk to the life of the inmate or to the life, health or welfare of any other person, or (b) that the life of an inmate will be at risk if the inmate continues to be detained in a correctional centre, or (c) that, because of illness, an inmate will not survive sentence or is totally and permanently unfit for correctional centre discipline, or (d) that an inmate should not, on medical grounds, be employed at work of a particular nature, or (e) that, because of an inmate's medical condition, the inmate is unfit to travel or should only travel by particular means, a prescribed health officer must report that he or she has formed the opinion, and the grounds for the opinion, to a prescribed CSNSW officer.
286. Mental Illness	(1) As soon as practicable after forming an opinion that the mental state of an inmate requires special observation, a prescribed health officer must report that he or she has formed the opinion, and the grounds for the opinion, to a prescribed CSNSW officer. (2) On receiving a report referred to in subclause (a), the prescribed CSNSW officer— must ensure the inmate is placed under special observation, and (b) in the case of a report with respect to a serious offender, must send written notice of the report to the Review Council.
287. Inmates' diet, exercise and treatment	(1) As soon as practicable after forming an opinion that an inmate's diet, exercise or other treatment should be varied or modified for reasons of health, a prescribed health officer must report that he or she has formed the opinion, and the grounds for the opinion, to a prescribed CSNSW officer. (2) On receiving a report referred to in subclause (a), the prescribed CSNSW officer— must take the steps that are reasonable to carry into effect any recommendation contained in the report, and (b) in the case of a report with respect to a serious offender, must ensure that written particulars of the report are kept available for reference by the Review Council. (3) If it is impracticable to carry a recommendation into effect, the prescribed CSNSW officer must report that fact to the Chief Executive, Justice Health and Forensic Mental Health Network.

288. Medical records	(1) Proper medical records are to be kept in respect of each inmate, with entries as to each examination that is carried out on an inmate by a prescribed health officer. (2) The medical records for inmates at a correctional centre are to be kept at the centre in the custody of a prescribed health officer, and their contents are not to be divulged to any person outside Justice Health and Forensic Mental Health Network (including the inmate) except in accordance with guidelines established by the Chief Executive, Justice Health and Forensic Mental Health Network. (3) Subclause (2) does not prevent information in an inmate's medical records being used to prepare general reports on the inmate's health for submission to the governor of a correctional centre, and any such report must be prepared and submitted whenever the governor so requests. (4) As soon as practicable after an inmate is transferred from one correctional centre to another, the inmate's medical records are to be given into the custody of a prescribed health officer at the centre to which the inmate is transferred. Subclause (4) does not apply if the inmate is temporarily transferred to a police station or court cell complex.
289. Provision of medical care to inmates confined to cell	An inmate who is confined to cell for the purposes of punishment, or under a segregated or protective custody direction, must be kept under daily observation by a prescribed health officer and have access to essential medical care.
290. Infectious diseases	(1) As soon as practicable after forming an opinion that an inmate has, or appears to have, a serious infectious disease, a prescribed health officer must report that he or she has formed the opinion, and the grounds for the opinion, to a prescribed CSNSW officer. (2) In the case of a report from the Chief Executive, Justice Health and Forensic Mental Health Network, the prescribed CSNSW officer must carry into effect any recommendation contained in the report in so far as it is practicable to do so. (3) If it is impracticable to carry a recommendation into effect, the prescribed CSNSW officer must report that fact to the Chief Executive, Justice Health and Forensic Mental Health Network. (4) In this clause, serious infectious disease means an infectious disease that is also a notifiable disease by virtue of its inclusion in Schedule 2 to the Public Health Act 2010.
291. Death of inmates	On becoming aware that an inmate has died, a prescribed health officer must report the death to the Commissioner

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