Adult health care inspection report 2023

Office of the Custodial Inspector
Tasmania

Inspection of adult custodial services in Tasmania

The Office of the Custodial Inspector acknowledges Tasmanian Aboriginal people as the Traditional Custodians of lutruwita/Tasmania. We recognise their continuing connection to Land, Sea, Waterways, Sky, and Culture and pay our respects to Elders, past and present.

Produced by the Tasmanian Custodial Inspector

About this report

This report describes the findings and recommendations from the Custodial Inspector resulting from inspections conducted June 2022 and February 2023.

It is available in print or electronic viewing format to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with a disability.

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Health and adult prisoners

Time in prison is usually temporary – in Australia, the median length of sentence in a correctional institution for the 2021-2022 financial year was eight months.[1] This, combined with over 60,000 receptions and 62,000 releases in the same period, means prison populations are relatively fluid.[2] Therefore, the health of the prison population and the health of the community are interconnected.

When compared with the general community, adults in custody generally have higher rates of mental health conditions, chronic disease and communicable diseases, and higher levels of drug and alcohol use.[3] In addition, adults in contact with corrective services are more likely to come from disadvantaged backgrounds, and have lived experience of homelessness and unemployment, than the general community.[4]

The inspections

This is the second round of inspections relating to the Mental Health Care, Physical Health Care and Substance Use Management standards. The first Mental Health Care inspection was undertaken in July 2017, and the Physical Health Care and Substance Use Management inspection was undertaken in May 2017.

An inspection against the Mental Health Care, Physical Health Care and Substance Use Management standards was originally planned to commence in March 2020. Due to the outbreak of COVID-19, and the public health measures

[1] Australian Bureau of Statistics (2023), 'Table 65: Defendants with a guilty outcome, selected principal sentence by sentence length and court level, 2021-22' [data set] in *Criminal Courts, Australia*, Australian Government, Canberra, www.abs.gov.au/statistics/people/crime-and-justice/criminal-courts-australia/latest-release accessed 14 September 2023.

[2] Australian Bureau of Statistics (2023), 'Table 21: Prisoner receptions into full-time custody, by sex and legal status' [data set] & Table 24: 'Prisoner releases from full-time custody, by sex and legal status' [data set] in *Corrective Services*, *Australia*, Australian Government, Canberra, www.abs.gov.au/statistics/people/crime-and-justice/corrective-services-australia/latest-release#data-downloads accessed 14 September 2023.

[3] Australian Institute of Health and Welfare (2019), *The health of Australia's prisoners 2018*, Cat. No. 246. Australian Government, Canberra, www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/summary accessed 16 March 2023.

[4] Ibid.

that were undertaken immediately after, the inspection was postponed.

The rescheduled inspections were undertaken in June 2022 for the Mental Health Care standards, and February 2023 for the Physical Health Care and Substance Use Management standards. I have made the decision to combine these two inspections into the one report as mental health, physical health and substance use are often connected and influenced by one another. The findings of both reports also emphasise the significant impact ongoing lockdowns have on both mental and physical wellbeing. The reports from our two consultants are attached at appendix 2 and 3.

Key issues

Lockdowns

Both the mental health consultant, Professor Norris and the physical health consultant, Dr Edward Petch highlighted the significant effects of lockdowns on prisoners' mental and physical health. At an individual prisoner level, these effects include increased frustration and irritability, anger, depressive symptoms, and a general decline in mental health and general wellbeing. There is also social isolation. Prisoners told my inspection team about the negative impact lockdowns have on their health:

> *Uncertainty around lockdowns, the not knowing if having [a] lockdown that day is very stressful. Get told at 8am over the loudspeaker. Doesn't help your mental health, not knowing if you're coming out.*
>
> *There's nothing to do.*
>
> *[With lockdowns] there is a sense of isolation.*

At a facility level, lockdowns reduce prisoners' access to healthcare. Insufficient correctional staff leads to prisoners being unable to attend healthcare centres throughout the prison or attend external medical appointments. In addition, the majority of CPHS staff are unable to go into facilities to undertake health care.

COVID-19

COVID-19 caused the postponement of the health inspections in 2020, so this is the first time that the response to COVID-19 has been inspected. COVID-19 in prisons poses a serious health risk to an already vulnerable population. From March 2020, prisons introduced a range of measures to reduce the spread of

COVID-19.[5] Dr Petch, stated in his report (appendix 3) that the response from Tasmania Prison Service (TPS) and Correctional Primary Health Services (CPHS) appeared to be world class. The effectiveness of the response was certainly reflected in the small number of prisoners who contracted COVID-19 in Tasmania – only 229 from the start of the pandemic to October 2022.

Part of the response to the COVID-19 pandemic was the suspension of in person visits at all TPS facilities. Video conference visits were introduced to continue contact for prisoners with their families and friends. While in person visiting has resumed, video conference visits have continued. This enables easy visiting options for prisoners who have family or friends who have difficulty attending in person visits, for example, because they live in the North or Northwest of the state. TPS is to be commended on increased access for prisoners to family visits and connections, an important factor in maintaining mental wellbeing.

Infrastructure

Both consultants highlighted how aspects of TPS infrastructure can affect prisoner health. Two infrastructure projects which have been completed since the 2017 Inspections are the expansion of the Inpatients Unit, and construction of the Southern Remand Centre (SRC), with the latter including clinical spaces and observation cells. These two spaces received positive feedback from Dr Petch, who noted that the SRC clinical spaces are well designed, and that the new expansion of the Inpatients Unit has resulted in a brighter and more therapeutic space than the older section of the Inpatients Unit.

Professor Norris has recommended that a designated inpatient unit be developed to better support the acute mental health needs of prisoners. The only unit currently available for managing acute mental health needs, the Crisis Support Unit (CSU) located in the Mersey Unit in Risdon Prison Complex (RPC)-Maximum, is a four bed, short-term accommodation option for managing prisoners with an acute risk of suicide and self-harm. TPS staff and CPHS staff told my inspection team that CSU had insufficient cells for the current mental health needs of the prison and that it needs to be made more therapeutic. Both Professor Norris and Dr Petch highlighted the untherapeutic nature of CSU.

The need to make CSU more therapeutic was noted in my 2018 Custody Inspection Report, and a recommendation made to address this issue. TPS indicated in their response to the recommendation that the commencement of

[5] Australian Institute of Health and Welfare (2022), *Health of prisoners*, Australian Government, Canberra, www.aihw.gov.au/reports/australias-health/health-of-prisoners accessed 22 September 2023.

the independent review of CSU had been delayed by the COVID-19 pandemic.[6]

Prisoners told my inspection team that the atmosphere in the CSU cells made them feel worse:

> *When I was in slash cell I was worse, you're in there by yourself, [when I] really needed to be closer to people.*
>
> *It's not good, drives you crazier, it's a cold dark environment [and you're] brought out once a day for an hour and can only access the phone then.*

Staff said that they would like to see a different environment in CSU, for example:

> *A more social environment, supported by staff to overcome the crisis.*
>
> *A more open environment where prisoners can be out of their cells during the day, walking with each other and talking to staff for support.*

One aspect highlighted by staff as less than ideal was the exercise area for prisoners in CSU. This area is attached to CSU and is enclosed by a wire cage which is close enough to the walkway between RPC-Medium and RPC-Maximum that other prisoners can see and communicate with a CSU prisoner. This is not conducive to helping the mental health of the prisoners housed in CSU, noting their vulnerable mental health, and that some may be wearing SASH gowns (which do not preserve their dignity). A garden has been created in the area between the walkway and the CSU exercise area, and a vine has been planted that will eventually grow up over the CSU exercise yard wire and provide more privacy to CSU prisoners. However, until then, the CSU exercise yard is exposed to the walkway. The 2018 Custody Inspection Report also highlighted the need to screen the CSU exercise yard.[7] The TPS response to a recommendation to install screening stated that it was seeking designs and costs for screening, noting that the current level of light in the exercise yard

[6] Office of the Custodial Inspector Tasmania (2020), *Annual Report 2019-20*, Office of the Custodial Inspector, Hobart, www.custodialinspector.tas.gov.au/__data/assets/pdf_file/0008/588275/Tasmanian-Custodial-Inspector-Annual-Report-2019-20.pdf.

[7] Office of the Custodial Inspector Tasmania (2019), *Custody Inspection Report 2019*, Office of the Custodial Inspector, Hobart, www.custodialinspector.tas.gov.au/__data/assets/pdf_file/0008/547199/Inspection-of-Adult-Custodial-Services-in-Tasmania,-2018-Custody-Inspection-Report.pdf.

should not be diminished.[8]

Figure 1 CSU exercise area, with arrow pointing to walkway between RPC Medium and RPC Maximum.

Oral health

Prisoners have poorer oral health than the general population; this is due to prisoners having poorer dental health prior to entering prison and barriers to providing dental care in prison.[9] Admission to prison provides an opportunity to improve the oral health of individual prisoners, and by extension, the outside community once a prisoner is released.[10] The 2017 Inspection noted the waiting lists for dental care were long. This situation remains problematic as long waits for access to dental care was mentioned repeatedly by prisoners when they were talking with my inspection team. Looking at the current waitlist for RPC and RBP, it would take approximately 14 months and nine months respectively, for all prisoners to receive dental care. These waiting times assume that no one is added to the list for dental care and there are no lockdowns.

The waitlist data likely under reports the true need for dental care. This is because prisoners triaged for dental services generally only include prisoners

[8] Office of the Custodial Inspector Tasmania (2020), *Annual Report 2019-20*, Office of the Custodial Inspector, Hobart, www.custodialinspector.tas.gov.au/__data/assets/pdf_file/0008/588275/Tasmanian-Custodial-Inspector-Annual-Report-2019-20.pdf.

[9] Booth J, O'Malley L, Meek R, Mc Goldrick N, Maycock M, Clarkson J, Wanyonyi-Kay K (2023), *A scoping review of interventions to improve oral health in prison settings*, Community Dentistry and Oral Epidemiology, 51(3):373-379, DOI: 10.1111/cdoe.1281.

[10] Ibid.

with serious dental issues such as infection, injury/trauma or severe pain. In addition, the waitlist also does not include the whole Tasmanian prison population. Prisoners on remand and prisoners with a sentence of less than six months are not able to access dental services in prison. Remand prisoners are approximately 39% of the total prison population. Prisoners sentenced to less than six months are approximately 8% of the total prison population.[11] Dr Petch details oral care on page 232 of his report and has recommended changes to the waiting list criteria and screening process and that dental services be doubled.

The public dental service in the community also provides the dental care in the prison, and my inspection team was told that dental care in the Tasmanian community is scarce. This scarcity is reflected in the median waiting time from listing date to first visit in 2021-22 of 1,281 days (3.5 years).[12] This lengthy wait time in the community further reinforces Dr Petch's recommendation 47 regarding cross referencing the prison and community dental waiting lists.

Medication

Two issues with medication have remained largely unchanged since the 2017 inspection. The first one is timely access to Panadol (paracetamol) after hours. The current protocol is to contact nursing staff after hours; however, there are no nursing staff on site after hours at the reception prisons and only two after hours nurses for the entire Risdon site. Dr Petch noted the ongoing problem of paracetamol access, and opined that over the counter medication, such as simple analgesics like paracetamol, should be more readily available in units. This certainly happens in other jurisdictions, for example, New Zealand has processes in place to enable their Correctional Officers to provide paracetamol to prisoners. These processes include a Panadol log sheet to ensure a prisoner doesn't exceed the maximum 24-hour dosage and to indicate when Correctional Officers should alert Health Services to assess a prisoner for further healthcare.[13] There is no further recommendation regarding increasing access to paracetamol in this Report, as the original 2017 recommendation is not yet

[11] Australian Bureau of Statistics (2023), 'Table 1: Persons in corrective services, summary' [data set] & Table 26: 'Sentenced prisoners, Indigenous status and aggregate sentence length by state/territory' [data set] in *Corrective Services, Australia*, Australian Government, Canberra, www.abs.gov.au/statistics/people/crime-and-justice/corrective-services-australia/latest-release#data-downloads accessed 14 September 2023.

[12] Australian Bureau of Statistics (2023), Dental care interactive 15. *Public dental services and waiting times data, states and territories, 2013-14 to 2021-22*, Australian Government, Canberra, www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-care accessed 22 September 2023.

[13] Ara Poutama Aotearoa Department of Corrections (n.d.), *Prison Operations Manual – Paracetamol (Panadol),* New Zealand Government, Wellington, www.corrections.govt.nz/resources/policy_and_legislation/Prison-Operations-Manual/Wellbeing/W.04-Hauora-Healthcare/W.04.02-Paracetamol-Panadol accessed 22 September 2023.

completed and is still marked as in progress.

The second issue is that medication that assists or promotes sleep is being provided to prisoners at the late afternoon medication round, undertaken daily at 4:00-4:30pm. Issuing these medications, and requiring that they be taken, at that time causes drowsiness and sleepiness during the late afternoon and early evening. Many prisoners complained, however, that they were then unable to sleep later in the night. This issue was highlighted by prisoners and CPHS staff to my inspection team during the 2017 inspection, although no recommendation was made in that report. When this issue was raised by Dr Petch with TPS and CPHS, both organisations agreed that there was no reason this medication could not be provided later in the evening. Dr Petch has made a recommendation regarding this evening medication round, including ensuring other time sensitive medication, such as psychotropic medication, is provided.

Recommendations

I have made a total of 117 recommendations arising from my two health care inspections. I outline one in the body of this report, which relates to the process of removing access from prison facilities for health staff and other non-TPS state servants that work in the prison. I have adopted the 27 recommendations Professor Norris has made in relation to mental health care and the 89 recommendations Dr Petch has made in relation to physical health care and substance use management. It is my hope that these recommendations, if implemented, will ultimately help to improve the conditions of detention for prisoners and thus TPS and CPHS workplaces and the community as a whole.

Twelve recommendations out of the 46 recommendations I made in 2017 have been completed in the five years between the first and second round of inspections. 23 recommendations are still in progress. This represents a missed opportunity to support the health care of prisoners.

The Department of Justice and the Department of Health's responses to my report can be found at Appendices 5 and 6.

Richard Connock

Custodial Inspector

June 2024

Acknowledgements

I would like to acknowledge the contribution of the consultants involved in the two inspections. Dr Kimberley Norris is a Professor of Psychological Sciences and a Clinical Psychologist at the School of Psychological Sciences, College of Health and Medicine, the University of Tasmania, who consulted on the Mental Health Care inspection. Dr Edward Petch is a Consultant Forensic Psychiatrist to Hakea Prison (Western Australia) and a Clinical Associate Professor at the University of Western Australia who consulted on the Physical Health Care and Substance Use Management inspection.

I sincerely thank Professor Norris and Dr Petch for their professional advice and assistance, which ensured my office had access to expertise on issues relevant to the Mental Health Care, Physical Health Care, and Substance Use Management inspection standards.

Acknowledgment and appreciation is also extended to all staff who engaged with the inspection team at the Department of Justice (DoJ) and Tasmania Prion Service (TPS) and the Department of Health (DoH) which includes Correctional Primary Health Services (CPHS). Whilst they are legislatively obliged to assist, their cooperation with the process is very positive.

As part of these announced inspections, management from DoJ, TPS and DoH were invited to provide a briefing to the inspection team. These briefings outlined in the various operational areas of adult custodial centres:

- recent achievements, current challenges and future perspectives; and
- an assessment of the strengths, weaknesses and opportunities.

I wish to thank the Departments for their submissions as they provided the inspection team with a sound understanding of the strategic direction being taken with regard to health care at the TPS sites.

I would like to thank the prisoners who shared their experiences with my team. I greatly value their contributions to these inspections.

About Tasmania Prison Service

TPS is responsible for providing care and custody, at various levels of security, for prisoners and people remanded in the five adult custodial centres in Tasmania.[14]

The five centres, and their capacities[15], are:

1. Risdon Prison Complex (RPC), located in Risdon Vale, 12 km from the Hobart CBD. It includes a medium and a maximum security precinct which have the capacity to house 196 and 103 prisoners respectively.
2. Ron Barwick Prison (RBP), including the O'Hara Cottages, located in Risdon Vale. It has the capacity to house 287 minimum rated prisoners.
3. Mary Hutchinson Women's Prison (MHWP), including the Dr Vanessa Goodwin Cottages, located in Risdon Vale. It includes maximum, medium and minimum rated units. It has the capacity to house 80 prisoners.
4. Hobart Reception Prison (HRP), in the Hobart CBD. It is a maximum rated prison and has the capacity to house 36 prisoners.
5. Launceston Reception Prison (LRP), in the Launceston CBD. It is a maximum rated prison and has the capacity to house 26 prisoners.

The Southern Remand Centre (SRC) is part of RPC and has the capacity to house 156 male remandees but was not operational at the time of the Mental Health inspection. SRC was operational at the time of the Physical Health and Substance Use Management inspection. SRC will be included in future Mental Health Care inspections. Prior to it being commissioned remandees were housed within the general prison population across the above TPS facilities. SRC enables most remandees to be housed separately from sentenced offenders, which is best practice for correctional facilities.[16]

The prison population increased between 2017 and 2020, decreased in 2021, remained steady in 2022, and increased in the first half of 2023 (Table 1). The

[14] Note: For the purposes of this report, a reference to the term prisoner includes people that are remanded and detained in custody.

[15] Tasmania Prison Service (26 February 2024), *Personal Communication*, Tasmania Prison Service

[16] United Nations Office on Drugs and Crime (2016), *United Nations standard minimum rules for the treatment of prisoners (the Nelson Mandela rules)*, United Nations, Vienna, p.5, www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf.

prison population is made up of both unsentenced and sentenced prisoners.[17] Unsentenced prisoners generally make up about one third of the total prison population.[18]

Table 1. Prisoners in TPS custody, 2017 - 2023

Year	Average daily number of prisoners		
	Female	**Male**	**Total***
2017	44	552	596
2018	43	584	626
2019	51	614	665
2020	53	603	656
2021	53	585	638
2022	48	590	638
2023#	46	669	715

*May include persons whose sex is unknown

#January to June 2023 data only

[17] Australian Bureau of Statistics (2020), 'Table 4: Persons in full-time custody' [data set], in *Corrective Services, Australia,* Australian Government, Canberra, www.abs.gov.au/statistics/people/crime-and-justice/corrective-services-australia/mar-quarter-2020#data-downloads accessed 20 November 2022;

Australian Bureau of Statistics (2023), 'Table 4: Persons in full-time custody' [data set] in *Corrective Services, Australia,* Australian Government, Canberra www.abs.gov.au/statistics/people/crime-and-justice/corrective-services-australia/latest-release accessed 15 September 2022.

[18] Australian Bureau of Statistics (2023), *Corrective Services, Australia*, Australian Government, Canberra, www.abs.gov.au/statistics/people/crime-and-justice/corrective-services-australia/latest-release#data-downloads accessed 20 November 2022.

About the Department of Health

The Department of Health (DoH), delivers mental health services to prisoners in TPS custody through two service arms: Correctional Primary Health Service (CPHS) and Forensic Mental Health Service (FMHS). Both of these service arms are under the governance of Statewide Mental Health Services.

CPHS provides primary health services and some mental health services to prisoners at TPS facilities, through onsite registered nurses (RNs), psychiatric liaison nurses (PLNs), Medical Officers, and psychiatrists.

FMHS provides specialist mental health services to prisoners including specialist psychiatric assessment and treatment services. In certain circumstances, prisoners may be transferred to the Wilfred Lopes Centre[19] for the purposes of assessment and treatment for mental illnesses.

[19] The Wilfred Lopes Centre is Tasmania's only secure mental health unit.

List of recommendations

I have made 117 recommendations as listed below.

Note: Numerical numbering of recommendations reflects the numbering used in the consultants' reports.

Recommendation A	The *Corrections Act 1997* be amended to ensure consultation at a senior level, appropriate to the circumstances, occurs prior to removing access to prison facilities for health staff and state servants. In the interim, the Director of Corrective Services, or their delegate, implement an internal process for consultation	Page 38

Mental health care

Professor Norris' report can be found at Appendix 2. It relates to both youth and adult custodial centres. Pages 101-140 relate specifically to adult custodial centres but Professor Norris notes that her recommendations pertain to all custodial settings unless otherwise specified which is why recommendations 2, 4 and 6 have been adopted below.

Recommendation 2	Employee Assistance Program (EAP) providers are specifically trained to understand and support staff working within custodial contexts	Appendix 2 page 79
Recommendation 4	As an interim measure, information be sought from other jurisdictions regarding their EAP providers and their organisational fit	Appendix 2 page 80
Recommendation 6	Review the Award Wages to ensure that these are competitive to the external market	Appendix 2 page 83

Reception Prisons

Recommendation 16	Increased access to natural light and consideration of mental health needs in renovations and redevelopments of Reception Prison facilities	Appendix 2 page 104
Recommendation 17	Mental Health training opportunities be provided to correctional staff in Reception Prisons	Appendix 2 page 107

Recommendation 18	Appropriate resourcing and governance structures to support transfer of offenders with higher/more complex (mental health) needs	Appendix 2 page 109
Recommendation 19	An MOU is entered into to facilitate assessments for treatment orders as required	Appendix 2 page 112
Recommendation 20	Increased provision of mental health supports and services for prisoners in Reception Prisons	Appendix 2 page 113
Recommendation 21	Increased health staffing/resourcing for adult prisoners	Appendix 2 page 116

Risdon Prison Complex

Recommendation 22	Urgently increase TPS staffing resources to protect prisoners and staff	Appendix 2 page 119
Recommendation 23	TPS and CPHS develop a designated inpatient unit for mental health presentations	Appendix 2 page 119
Recommendation 24	Develop and engage with, best practice models which cater to the needs of the Tasmanian adult prison population	Appendix 2 page 121
Recommendation 25	TPS encourage and support peer mentoring and embed in formal workloads	Appendix 2 page 122
Recommendation 26	Staff mental health training be embedded into onboarding and ongoing professional development frameworks	Appendix 2 page 122
Recommendation 27	Reflective practice and other forms of peer supervision be integrated into workload for all staff	Appendix 2 page 123
Recommendation 28	Consider recruiting a staff member in Mary Hutchinson Women's Prison to the MATES framework	Appendix 2 page 124
Recommendation 29	Support TPS staff requests for training from mental health staff to increase mental health literacy, interdisciplinary learning and more coordinated mental health support for prisoners	Appendix 2 page 124
Recommendation 30	A psychologist with specific knowledge and skills related to gang and terrorism behaviour continues to work with TPS in a consultant role to develop methods to manage prisoners posing a risk to others	Appendix 2 page 126

Recommendation 31	Development of a structured, standardised and integrated system to assist in record management for offender mental health data	Appendix 2 page 128
Recommendation 32	Existing policies are reviewed and updated to ensure that the mental health and wellbeing needs of staff working in a complex extreme and unusual environment typified by exposure to potentially traumatic events are appropriate to the context	Appendix 2 page 131
Recommendation 33	Develop and review governance structures to better account for mental health and wellbeing needs of staff and prisoners as a matter of priority, ensuring these reviews are workloaded appropriately to ensure meaningful engagement and associated outcomes	Appendix 2 page 131
Recommendation 34	Implement a formal professional development framework in RPC to support implementation and consolidation of evidence-based, contemporary practices relating to therapeutic climate and therapeutic jurisprudence	Appendix 2 page 133
Recommendation 35	Health staff liaise with correctional staff to ensure that mental health screening and monitoring is considered as part of the dry cell management procedure	Appendix 2 page 135
Recommendation 36	As a matter of priority, develop policy or documentation regarding the management of the mental health needs of older and very old prisoners	Appendix 2 page 136
Recommendation 37	Adopt early intervention models of mental health care	Appendix 2 page 136
Recommendation 38	Additional resourcing of existing research units/engaging with partners to undertake robust targeted mental health research focused on custodial contexts	Appendix 2 page 137
Recommendation 39	Identify and implement evidence-based/evidence-informed targeted intervention programs of shorter duration for prisoners within the RPC serving sentences of shorter duration	Appendix 2 page 139

Physical health care and substance use management

Dr Petch's report can be found at appendix 3. It relates to both adult and youth custodial centres but the vast majority is about adult custodial facilities.

Introduction

Recommendation 1	TPS and Correctional Primary Health Services (CPHS) develop a set of principles for the delivery of healthcare services and monitor their services against these principles.	Appendix 3 page 178

Access to care

Recommendation 2	If prison lockdowns are urgently required for regular training, they occur a maximum of one day per month.	Appendix 3 page 180
Recommendation 3	During prison lockdowns, each prisoner who is confined to their cell is considered to be in a state of segregation.	Appendix 3 page 183
Recommendation 4	Prisoners in segregation have at least one hour out of their cell every day in line with the *Corrections Act 1997* and international humanitarian obligations.	Appendix 3 page 184
Recommendation 5	People who are mentally ill are not subject to segregation unless it is by a specific order, such as disciplinary segregation or medical segregation.	Appendix 3 page 185
Recommendation 6	People in segregation should be medically reviewed according to international guidelines.	Appendix 3 page 186
Recommendation 7	CPHS staff receive the appropriate training to be permitted to walk within the maximum and medium security parts of the prisons unaccompanied.	Appendix 3 page 186
Recommendation 8	CPHS ensure appropriate standards relating to waiting times to see doctors are set and audited in a rolling cycle.	Appendix 3 page 187
Recommendation 9	The business case for expansion of the available staff base with the opening of Southern Remand Centre (SRC) is reviewed and resubmitted.	Appendix 3 page 189

Recommendation 10	Staff on workers compensation considered to be permanently incapacitated should be removed from the TPS staffing establishment to enable recruitment into their vacant full time equivalents (FTEs).	Appendix 3 page 190
Recommendation 11	TPS and the unions are both encouraged to reach agreement about staff numbers required to fully operate the prison and the threshold for when lockdowns are required on the basis of staff shortages.	Appendix 3 page 191
Recommendation 12	TPS Senior Management Team (SMT) seeks external advice from a management consultant regarding the development of a change management process to replace the command and control culture into a more contemporary and effective management approach.	Appendix 3 page 193
Recommendation 13	TPS SMT seek external advice from a strategic human resources management consultant regarding the development of an effective staff recruitment and retention strategy.	Appendix 3 page 195
Recommendation 14	The Director of Corrective Services considers granting prisoners in segregation during lockdowns special management days to the equivalent time they have been in lockdown and that this time is remitted from their sentence.	Appendix 3 page 196

Governance and administration

Recommendation 15	Training be provided for correctional staff about the role of health staff and vice versa.	Appendix 3 page 198
Recommendation 16	Review the Letter of Intent between the Department of Health and the Department of Justice, and this to be shared with all staff from CPHS and TPS.	Appendix 3 page 199
Recommendation 17	TPS to bring all standard operating procedures and Director's Standing Orders/Secretary's Instructions relating to healthcare services up to date and keep them under review.	Appendix 3 page 204
Recommendation 18	CPHS Clinical Speciality group needs to meet at least six times per year.	Appendix 3 page 205

Recommendation 19	CPHS acknowledge patients' medical requests and give a date by when they will be actioned or reasons why they will not.	Appendix 3 page 206
Recommendation 20	Alert patients of their medical appointments without announcing it to the entire unit.	Appendix 3 page 207
Recommendation 21	CPHS acknowledge the receipt of complaints and provide a date by which they will be investigated and if appropriate, actioned.	Appendix 3 page 209
Recommendation 22	Feed findings from complaints into the Clinical Speciality Group for introduction into the clinical improvement process.	Appendix 3 page 209
Recommendation 23	CPHS to establish a regular meeting with the Health Complaints Commissioner to discuss complaints, trends and outcomes.	Appendix 3 page 209
Recommendation 24	All CPHS health staff need access to peer support and supervision, training, skills and career develop opportunities, cultural diversity training, and regular updates in clinical practice.	Appendix 3 page 211

Safety

Recommendation 25	Provide more shaded areas to the yards in the SRC.	Appendix 3 page 214
Recommendation 26	Review the terms of reference, including operation and membership, of the Use of Force Review Panel with the view to increase community input, including the Tasmanian Aboriginal community.	Appendix 3 page 215
Recommendation 27	Provide, as a minimum, the Dedicated Response Team (DRT) and officers working with watch-house detainees with body cameras.	Appendix 3 page 216
Recommendation 28	Obtain prisoner perspectives after every use of force so they can be fed back into the review of the incident.	Appendix 3 page 216
Recommendation 29	Review the violence reduction strategies that are in use to ensure they are contemporary.	Appendix 3 page 217
Recommendation 30	The State Government to consider how people on workers compensation can access the psychiatric care they require.	Appendix 3 page 218

Recommendation 31	Consider how best to support people on workers compensation or sick leave, especially in light of the Wellbeing Officer role no longer being funded.	Appendix 3 page 219

Patient care and treatment

Recommendation 32	Consider increasing nursing staff on duty in Hobart Reception Prison (HRP), as is done with correctional officers, during evenings and nights when there are public events likely to involve large crowds and substance use which may result in high numbers of arrests.	Appendix 3 page 220
Recommendation 33	The medication management committee/ drugs and therapeutic committee should ensure all aspects of prescribing practice are in accordance with an established set of clinical guidelines for prescribing in correctional settings. Prescribing guidelines need to be developed where these differ from community treatment guidelines. A formulary needs to be agreed with clinicians.	Appendix 3 page 222
Recommendation 34	All medication changes made at the point of admission (and thereafter) should be discussed with the patient before they are made. Until then drugs prescribed in the community should be continued unless contraindicated; wherever possible community health providers should be contacted for treatment information, and proposed changes discussed.	Appendix 3 page 224
Recommendation 35	Electronic prescribing is established	Appendix 3 page 225
Recommendation 36	Historical paper medication charts should be moved and stored off site in a central location.	Appendix 3 page 225
Recommendation 37	The policy and practice regarding drug availability in imprests in various sites should be reviewed and standardised and brought into accordance with Tasmanian pharmaceutical regulations. If pharmacy input is required at Launceston Reception Prison (LRP) this should be organised.	Appendix 3 page 227
Recommendation 38	Commonly required medication should be available in imprests to avoid gaps in medication administration.	Appendix 3 page 227

Recommendation 39	Evening medication rounds should be established particularly for sedating or psychotropic medication.	Appendix 3 page 228
Recommendation 40	A multi-agency review of medication security should be undertaken with a view to enhancing it where possible, so reducing the potential for trafficking of medication and therefore increasing the use of medication that is therapeutically useful but deemed trafficable.	Appendix 3 page 229
Recommendation 41	The use of on-person medication be reviewed.	Appendix 3 page 230
Recommendation 42	Over the counter medication should be more readily available in the units. TPS and CPHS should work to establish an effective policy to implement this.	Appendix 3 page 230
Recommendation 43	CPHS consider creating a list of medication that nurses across the prisons are permitted to dispense both with, and without, a prescription.	Appendix 3 page 230
Recommendation 44	Medication be sent with prisoners to court with personal belongings as a matter of routine.	Appendix 3 page 232
Recommendation 45	The post release medication practices should be reviewed and at least one week's medication should be sent with prisoners who are attending court or who are being released.	Appendix 3 page 232
Recommendation 46	The criteria for access to dental care should be reviewed to include all patients, both sentenced and remandees, who meet the clinical criteria for care and they should be screened against these criteria by staff trained in dental triage.	Appendix 3 page 233
Recommendation 47	CPHS should work with Oral Health Services to review and amalgamate the correctional and community waiting list to ensure people are not disadvantaged regarding their waiting times for dental treatment by virtue of changes to their custodial or legal status.	Appendix 3 page 234
Recommendation 48	Dentistry services at the prison need to be doubled without delay.	Appendix 3 page 235

Recommendation 49	CPHS to review input provided by allied health professionals and business cases prepared to increase input to meet demand where necessary.	Appendix 3 page 235
Recommendation 50	Upgrade and mend the broken fittings in the Inpatients Unit.	Appendix 3 page 236
Recommendation 51	Refurbish the areas of the old Inpatients Unit.	Appendix 3 page 236
Recommendation 52	Review TPS and CPHS staffing of the Inpatients Unit, particularly the reallocation of TPS staff to other areas during lockdowns.	Appendix 3 page 237
Recommendation 53	Review the use of the Inpatients Unit, the medical procedures that could and should be undertaken there, and deliver appropriate training to staff as soon as practicable to reduce the number of escorts to hospital.	Appendix 3 page 237
Recommendation 54	Review the security needs of the Inpatients Unit to allow immediate medical access to all rooms.	Appendix 3 page 238
Recommendation 55	Review the use, function and infrastructure of the Crisis Support Unit (CSU) to ensure it is a therapeutic space.	Appendix 3 page 239
Recommendation 56	Increase number of medical escorts to hospital back to 8 per day without delay. This will take some work regarding resourcing, but it should be a priority.	Appendix 3 page 239
Recommendation 57	CPHS and TPS work with Royal Hobart Hospital (RHH) to plan the implementation of secure areas in the refurbished Emergency Department so they can be used by prisoners and escorting staff.	Appendix 3 page 240
Recommendation 58	Develop a Memorandum of Understanding (MOU) with RHH and Launceston General Hospital (LGH) regarding mutual expectations and ways of working with prisoners to ensure their safety and welfare as well as that of the public. The MOU with RHH and LGH should also consider introducing regular visits of specialists to the prisons.	Appendix 3 page 241
Recommendation 59	Review arrangements regarding escorts. Consider outsourcing of the transport function to an external provider while TPS is unable to staff the function to sufficient levels.	Appendix 3 page 241

Recommendation 60	CPHS to liaise with TPS staff in good time regarding escorts required.	Appendix 3 page 242
Recommendation 61	Increase use of video-conferencing and telehealth for healthcare, wherever possible, with outpatient clinics to minimise escorts required.	Appendix 3 page 242

Special needs and services

Recommendation 62	Review the level of information and support required regarding the management of menopause and related symptoms.	Appendix 3 page 243
Recommendation 63	Incorporate the Volunteers for Change program into the male estate and into the CPHS clinical governance program.	Appendix 3 page 243
Recommendation 64	TPS reintroduce the peer support service into Mary Hutchinson Women's Prison (MHWP).	Appendix 3 page 244
Recommendation 65	Develop Alcohol and Other Drug (AOD) rehabilitation services for women to reflect their level of need.	Appendix 3 page 244
Recommendation 66	Mental health input to the MHWP may require review. An audit of need should be conducted and the input provided should reflect the level of assessed need.	Appendix 3 page 244
Recommendation 68	TPS and CPHS should conduct a recruitment drive targeted towards Aboriginal and Torres Strait Islander people.	Appendix 3 page 247
Recommendation 69	CPHS should ensure that culturally appropriate care is provided to people from Aboriginal and Torres Strait Islander communities.	Appendix 3 page 247
Recommendation 70	The need for transitional case management needs to be reviewed given the impact it can have on recidivism. Transitional case manager positions should be created and a manager appointed.	Appendix 3 page 248
Recommendation 71	Assistance to those with disabilities to complete the requisite forms for services should be provided.	Appendix 3 page 250
Recommendation 72	TPS and CPHS establish protocols to ensure prisoners have appropriate access to voluntary assisted dying.	Appendix 3 page 250

Recommendation 73	Evaluation of the effectiveness of criminogenic programmes, especially in relation to substance use management, should be undertaken.	Appendix 3 page 252
Recommendation 74	An alternative base for the Programs Team should be found so they are not accommodated in prison cells.	Appendix 3 page 252
Recommendation 75	Criminogenic programs, especially those containing information about substance use management, should be reinstated within the prison service. They should be closely linked to community services, and ideally straddle delivery of program services in the community after the participant's release.	Appendix 3 page 253
Recommendation 76	Criminogenic programs, especially those containing information about substance use management, should be available to women when required.	Appendix 3 page 253

Patients with alcohol and other drug problems

Recommendation 77	Review the policy regarding supports provided for tobacco cessation to ensure the humane treatment of those dealing with nicotine addiction and withdrawal.	Appendix 3 page 256
Recommendation 78	Improve conditions within the dry cell, which is used to house prisoners suspected of internally concealing contraband, including installation of a call button and increasing frequency of levels of observation.	Appendix 3 page 258
Recommendation 79	Increase screening of staff, contractors and visitors on entry and at random (including drug testing).	Appendix 3 page 258
Recommendation 80	Base AOD waiting lists on all those who require the service, not on legal status. Use this waiting list to assist making the case for development of AOD services.	Appendix 3 page 260
Recommendation 81	Deliver AOD treatment to people who require it rather than limiting treatments to those for whom community services are being allocated.	Appendix 3 page 261
Recommendation 82	Review policy and protocols regarding management of alcohol and drug withdrawal to ensure adequacy of care.	Appendix 3 page 263

Recommendation 83	Include therapy as part of the opiate replacement program as per treatment guidelines.	Appendix 3 page 264
Recommendation 84	Review criteria for placement on Opioid Replacement Therapy (ORT).	Appendix 3 page 265
Recommendation 85	The leadership and structure of the delivery of AOD services is reviewed to ensure it is fit for purpose, contemporary and meets the needs of the prison population.	Appendix 3 page 266
Recommendation 86	Parameters of eligibility for all AOD treatments and programs need to be created which reflect patient need. Criteria based purely on legal parameters (e.g. remand status) should be abolished. Waiting lists should be then used where necessary to demonstrate service insufficiency. Adequate support and clinical supervision for AOD staff, including off site support where required, should be structured into the program and fully funded to enable all treating staff to have sufficient access as part of the role a. A space be identified for the delivery of a residential AOD therapeutic program pending the outcome of the business case for development of Division 8 in Ron Barwick Prison (RBP). Suitable prisoners should be identified for the program, moved to this area and the program initiated without delay. Whilst the program could be structured around the principles of Pathways, it needs multidisciplinary input and close integration with community AOD services, and with community services. Any carefully generated culture needs maintenance, or it can erode over time and this reduces program effectiveness. b. Custodial and therapeutic staff for this unit should be carefully selected. c. The effectiveness of the program should be evaluated.	Appendix 3 page 267
Recommendation 87	Develop a business case for the establishment of an adequate number of AOD counsellor positions.	Appendix 3 page 268
Recommendation 88	Introduce bleach needle-washing facilities and/or introduce needle exchange facilities.	Appendix 3 page 269

Recommendation 89	AOD services deliver a range of education programs to CPHS staff and TPS staff regarding drug use in prison and treatment approaches	Appendix 3 page 270
Recommendation 90	Develop a multi-agency interdisciplinary model of care for AOD service provision which extends into the community and uses the services of community providers who have contracts or Service Level Agreements (SLAs) to deliver coordinated services.	Appendix 3 page 271

Inspections, standards and methodology

Inspections

The purpose of the Custodial Inspector is to provide independent, proactive, preventative and systemic oversight of custodial centres. The definition of a custodial centre includes a prison within the meaning of the *Corrections Act 1997.*

Section 13 of the *Custodial Inspector Act 2016* requires me to carry out a mandatory inspection of each custodial centre at least once every three years. Section 15 of the *Custodial Inspector Act 2016* requires me to prepare a report to the responsible Minister outlining my findings and recommendations in relation to each mandatory inspection. I report directly to the Minister responsible for the custodial centre and the Minister is required to table a copy of my report in each House of Parliament. In this way, inspection findings and recommendations become a public record. After tabling, all inspection reports are published on the Office of the Custodial Inspector website[20]

To meet my legislative obligations using the limited resources available, my office undertakes themed inspections of custodial centres focussing on particular inspection standards. At the end of a three year cycle, all aspects of custodial centres will have been inspected against the entire set of inspection standards. Due to the outbreak of COVID-19 and the public health measures that were undertaken immediately after, planned inspections were postponed. Unfortunately this has meant we are currently behind schedule on inspecting all of the standards within the three year cycle.

Prior to publication of this report, the Department of Justice (DoJ) and Department of Health (DoH) were consulted and invited to correct any factual inaccuracies and to provide a written response to the recommendations included in this report. Appendices 5 and 6 detail those responses.

Standards

The *Inspection Standards for Adult Custodial Centres in Tasmania* provide the structure for reviewing and assessing the performance of custodial centres in relation to the treatment of, and conditions for, adults in Tasmania.

The inspection standards are publicly available on the Office of the Custodial

[20] Office of the Custodial Inspector Tasmania (2023), *Publications*, Office of the Custodial Inspector, Hobart, www.custodialinspector.tas.gov.au/inspection_reports.

Inspector's website.[21] The inspection standards relevant to this report are listed in Appendix 1.

Inspections provide independent, external evaluation of custodial centres against the Adult Inspection Standards. An independent perspective can identify issues – both shortcomings requiring improvement and strengths that can be better utilised – that may not be immediately apparent to the custodial centre, thereby providing a continuous improvement framework.

Methodology

During the inspection, a number of evidence sources were used to assess adult custodial centres against the inspection standards. These included:

- onsite visits;
- meetings with senior management;
- individual interviews carried out with staff;
- conversations with prisoners;
- review of documentation; and
- observation by the inspection team and the expert consultants

[21] Office of the Custodial Inspector Tasmania, *Standards and guidelines*, Office of the Custodial Inspector, Hobart, www.custodialinspector.tas.gov.au/standards_And_guidelines.

Follow up issue

Most of our findings and recommendations can be found in Appendices 2 and 3, being the reports from our consultants Professor Kimberly Norris and Dr Edward Petch. I have expanded on a matter below, however, in light of additional information gathered after the inspections. This matter relates to an incident involving a CPHS medical officer's access to RPC being removed.

The removal of a CPHS medical officer's access to RPC and the impact on medical autonomy

Delivering health care in prison is a joint effort of correctional staff and health staff and requires cooperation between correctional staff and health staff.[22] Cooperation requires effective communication. To achieve this, each staffing group should understand the other's motivation and priorities, as they will be different .[23] Health care staff are trained to provide care and have a responsibility to advocate and preserve the rights of the custodial patient. Correctional staff have different but complementary priorities: to ensure the safety and security of prisoners, staff, and the facility.[24] This cooperation is an ideal scenario. How health care delivery occurs in reality can be different, when both correctional and health staff encounter real life situations.

Dr Petch explored an incident that occurred in the midst of our inspection that arguably demonstrated a significant cultural and communication problem regarding medical autonomy within the Tasmania Prison system. He outlined the incident at page 199 onwards of his report. The incident related to the Director of Prisons removing a female medical officer's access to enter RPC. The medical officer is employed by CPHS and works at RPC and a number of

[22] Corrective Services Administrators' Council (2018), *Guiding Principles for Corrections in Australia,* Corrective Services Administrators' Council, Canberra, files.corrections.vic.gov.au/2021-06/guiding_principles_correctionsaustrevised2018.pdf accessed 16 June 2023;

National Commission on Correctional Health Care (2021), *The importance of custody-health care collaboration, part 1,* National Commission on Correctional Health Care, Chicago, www.ncchc.org/the-importance-of-custody-health-care-collaboration-part-1/ accessed 16 June 2023.

[23] National Commission on Correctional Health Care (2021), *The importance of custody-health care collaboration, part 1,* National Commission on Correctional Health Care, Chicago, www.ncchc.org/the-importance-of-custody-health-care-collaboration-part-1/ accessed 16 June 2023.

[24] Royal Australian College of General Practitioners (2019). *Custodial health in Australia: tips for providing healthcare to people in prison*, RACGP, East Melbourne, www.racgp.org.au/FSDEDEV/media/documents/Faculties/SI/Custodial-health-in-Australia.pdf accessed 16 June 2023;

National Commission on Correctional Health Care (2021), *The importance of custody-health care collaboration, part 1,* National Commission on Correctional Health Care, Chicago, www.ncchc.org/the-importance-of-custody-health-care-collaboration-part-1/ accessed 16 June 2023.

other Tasmanian prisons but only their access to RPC was removed.

This incident happened towards the end of the inspection, meaning there was limited information available to the consultant for his report. In the weeks after the inspection was completed, my inspection team spoke to CPHS and TPS stakeholders, and external stakeholders, to gain a more complete understanding of how and why this incident occurred. I have further explored the incident below, using this additional information. Dr Petch reviewed this additional information before publication, and as he has indicated in his report, it did not cause him to change his opinion. As Dr Petch has noted, his report and this additional information should be read together. A response from the Director of Prisons can be found in Dr Petch's report and the Department of Justice's response to this issue can be found at page 296 of Appendix 5 – Department of Justice response to reports. The Department of Health did not have any comments regarding this issue in its response to the inspection report at Appendix 6.

I explored this incident in further detail as I was concerned that it might have been demonstrative of potential systemic issues relating to medical autonomy. It highlighted issues concerning CPHS staff's right to access their place of work, the potential repercussions of conflict between the two services and the significant power differentials and the impacts this ultimately has on the delivery of a core service – health care for people in custody.

The access removal occurred in the RPC security screening area, in front of a number of TPS and CPHS staff, with no prior warning to the Medical Officer and minimal warning to CPHS. TPS had emailed the CPHS leadership team that morning and had intended to meet the Medical Officer when she came into RPC security screening and talk to her and explain what was happening. However, within five minutes of the email being sent and the Custodial Officers (COs) at the RPC security screening being told the Medical Officer's access had been removed, the Medical Officer attempted to enter RPC and was told by the COs that her access had been removed. The CPHS leadership team was also entering at the same time and had not yet read the email sent by TPS.

A number of CPHS staff and the Australian Medical Association (AMA) Tasmania noted that the Medical Officer was distressed and humiliated because TPS provided no information about why her access had been removed and that it had occurred so publicly. TPS indicated later to my inspection team that this way of doing it was not ideal, and CPHS agreed. A senior TPS officer said:

> *In an ideal world, the clunkiness of the day would not have happened, [we] would have been able to talk to [the Medical Officer] in a private room .*

After several meetings between CPHS and TPS on that day and the next, TPS restored access to RPC for the Medical Officer the next day. CPHS apologised to TPS for how they had dealt with TPS in the days leading up to the access removal. The Director of Prisons apologised to the Medical Officer for how the access removal had been managed.

Lead up to access removal

Both CPHS and TPS identified in the days leading up to the access removal, there had been several interactions between the Medical Officer and TPS staff. These interactions informed the Director of Prison's access removal decision.

One interaction concerned the Medical Officer attending SRC for the usual Tuesday afternoon health clinic, which runs from 1 to 3 p.m. The Medical Officer was unable to attend SRC clinic until 2 p.m. and spent the next hour reviewing medications (ready for the nurse-led medication round at 3 p.m.) and reviewing nurse initiated photos of prisoner's wounds and other medical conditions rather than seeing prisoners.

CPHS staff indicated to my inspection team that clinical work was not just seeing prisoners face to face, and that the work undertaken that afternoon by the Medical Officer was still necessary clinical work that had to be completed. TPS expressed concern that the Medical Officer told the SRC CO that she would be doing paperwork and then shut her office door. The CO then reported this to the Superintendent.

The other interactions were associated with the medical treatment of two prisoners, specifically their need to attend, or remain in, the Royal Hobart Hospital (RHH) for appropriate treatment. Dr Petch explored the more recent matter on page 199 of his report. CPHS staff said that they were advocating for their patients, who needed to access health care at the RHH, and given the recent lack of COs leading to health clinics not being operated, didn't feel that TPS would be able to ensure transport was available for the prisoners' required daily appointments at the RHH.

TPS staff outlined in the more recent matter that the RHH had cleared for the patient to return. TPS staff said that their role is to ensure the safety and security of the prison, and a significant factor in this is making sure the prison is unlocked as much as possible, and for that they need COs on the floor. TPS felt that they weren't getting support from CPHS to ensure that TPS could facilitate unlock as much as possible, as any prisoner at the RHH must be accompanied by COs, and this reduces the amount of COs at TPS facilities to enable unlocking.

These interactions between CPHS and TPS appeared to only deal with the surface issue, rather than understanding the multi-layered and nuanced needs

of the individual prisoners, the prison as a whole, and the staff who work in the prison (both CPHS and TPS). The interactions showed an incomplete understanding of each other's daily work, and all that might be involved beyond the surface level of patient consultations and unlocking the prison.

Basis of access removal decision

The decision to remove access for the Medical Officer was made by the Director of Prisons. He told my inspection team of a situation being described to him by TPS staff as a "relationship [between CPHS and TPS] that was rapidly deteriorating" and felt that a circuit breaker was needed. This circuit breaker was to remove the visitor access of the Medical Officer to RPC to give TPS time to assess the situation and to talk to the Medical Officer.

CPHS staff enter TPS facilities as visitors under the *Corrections Act 1997*, even though the TPS facilities may be their primary and permanent place of work.

Section 19 of the *Corrections Act 1997* enables the Director of Corrective Services, or their delegate such as the Director of Prisons, to remove a visitor from the prison. I understand this was the section relied upon to remove the Medical Officer's access to RPC. That section is in the following terms:

> ***19. Director may refuse or terminate visits for security reasons***
>
> *(1) If the Director believes on reasonable grounds that the security of a prison or the safety of a visitor at a prison is threatened, the Director may –*
>
> > *(a) by order prohibit a person from entering the prison as a visitor; or*
> >
> > *(b) order the visitor to leave the prison immediately.*
>
> *(2) A person who disobeys a Director's order under this section is guilty of an offence.*
>
> *Penalty: Fine not exceeding 5 penalty units.*

Based on the material my inspection team considered and the information from staff they spoke to, including staff who advised the Director before he made his decision, we expressed the view that it was difficult to understand how the security of the prison was threatened by a Medical Officer advocating for their patients' care. We questioned whether the belief about there being a threat to the security of a prison was based on reasonable grounds.

The Director of Prisons told my inspection team that he based his decision

making on his almost 40 years of experience working in prisons, and knowing how quickly a situation can escalate and get out of control. He spoke about the potential of the Medical Officer to cause, and escalate, conflict between staff and between staff and prisoners, in the context of the interactions mentioned previously. He indicated that if, as he was being told by TPS staff, the Medical Officer was doing paperwork in SRC for three hours, while the CO was having to manage angry prisoners waiting for health care, that this had the potential to lead to either the CO or the Medical Officer being assaulted by prisoners. The Director also referred to advice he received about the Medical Officer being adversarial regarding whether patients should return from RHH, even though the patients' continued presence at RHH impacted the number of COs available for unlocking the prison and the RHH advised they could return.

We also queried why the Medical Officer was banned from only one prison if there were concerns about her causing conflict. The Director of Prisons said that there may be times when it's relevant to ban someone from all facilities, but on this occasion however it was simply about RPC needing a circuit breaker.

Other stakeholders also questioned the selectiveness of the ban. My inspection team spoke with AMA Tasmania, the professional body representing doctors in Tasmania, including the Medical Officer involved in this matter. The Vice President told my inspection team that the "*decision made no sense*", and queried why, if access was removed on the basis of the security of the prison being threatened, wasn't the Medical Officer classed as security threat for all facilities?

As outlined above, the Director said that he removed the access as a circuit breaker but in my view, consultation and discussion with the Medical Officer and her supervisors would have been a more reasonable first step. The exercise of the discretion to remove the Medical Officer's access, as the first option, was inappropriate and without sufficient justification.

Relevance of gender consideration in access removal

The gender of the Medical Officer was raised with us by multiple parties as being relevant to her removal of access. My inspection team consequently questioned a number of stakeholders about whether gender played a role in this access removal. CPHS staff we spoke to, both male and female, felt that the female gender of the Medical Officer was a factor. We were told about male CPHS staff advocating for their patients over the years, including some occasions involving shouting arguments. These advocacy episodes have not elicited a similar response regarding ongoing access to prison facilities. We spoke to the senior TPS staff, including the Director of Prisons, who were involved in the incident. These staff, all of whom were male, denied gender played a role. The Director said the decision would have been the same if the

Medical Officer was male.

The AMA Tasmania Vice President, Dr Annette Barratt, considered that gender could have played a role in what happened. Dr Barratt indicated that she "*had spoken with female doctors at TPS over the years. The gender issue is ongoing*".

Considering my view that the decision to remove the Medical Officer's access was unreasonable and concerns were raised with my team about the role of gender, it was fair to consider if irrelevant considerations played a role in the decision-making process. I have not found any evidence that gender was a factor or had a role in the decision made by the Director of Prisons. In reaching this view, however, I do not disregard the various experiences and perceptions of those involved. Anecdotally, gender does appear to be an issue in the workplace.

Impact on CPHS and TPS relationship

My inspection team attended a regular monthly meeting between CPHS and TPS executive staff, prior to the inspection and this incident, and observed that there was a good working relationship. The same could not be said of the working relationship between CPHS and TPS at the operational level and Dr Petch has explored some of the issues observed during the inspection in his report.

Both CPHS and TPS have said that while relationships were damaged in the short term as a result of this incident, they are now stronger due to the incident. Based on my observations, I would agree. It was unfortunate, however, that the improvement came along with an emotional toll on many CPHS and TPS staff.

Both services have since recognised that they have been lax regarding communicating with each other, especially on an operational level. CPHS and TPS have indicated that while it is a work in progress, there have been some positive outcomes from this episode. These include:

- Protocols being developed regarding how CPHS and TPS work together.
- CPHS and TPS are working on an escalation process/flowchart. This will reflect the current Letter of Intent between DoJ and DoH 'Delivery of health services to prisoners within the Tasmania Prison Service' but will be one page and clearly describe the escalation process. This will be sent to all managers and anyone who might be on-call after hours.
- There is increased communication between CPHS and TPS, and there are more forums to facilitate this communication.
- TPS has increased facilitation between CPHS and prisoners needing health care, for example, taking CPHS Medical Officers into facilities to

treat prisoners when the Outpatients clinic is closed due to insufficient TPS staff, a significant improvement for the welfare of prisoners.

- A better understanding of how each other works. This includes an increased understanding for CPHS regarding how their decisions affect TPS, and creating training to ensure TPS understands how CPHS work and what they do.

That both CPHS and TPS have recognised that the relationship needs to be addressed, and are undertaking steps to do this, is to be commended.

It is my view that the unequal relationship between TPS and CPHS requires balance. Trust needs to be restored as CPHS staff must have confidence that they can advocate for their patient's best interest without fear of reprisal. I have recommended legislative change, to require consultation appropriate to the circumstances at a senior level before access to TPS facilities is removed for health staff and non-Department of Justice state servants who work in prisons as 'visitors'. I have specified state servants, as well as health staff, because they also provide important rehabilitative services, such as education. They should also have sufficient confidence that the treatment the Medical Officer received is not repeated.

Arguably, if a state servant's conduct is so severe as to threaten the safety of a visitor or the security of a TPS facility, it is likely there are grounds for them to be immediately suspended in any event under Employment Direction 4 – Procedure for the Suspension of State Service Employees with or without Pay. If this is not possible, Employment Direction 4 is not working as it ought to.

The intent of the recommendation below is to ensure in the future that decisions to remove access to TPS facilities for health staff and non-TPS state servants, based at the prisons, are not made unilaterally.

Recommendation A

The Corrections Act 1997 be amended to ensure consultation at a senior level, appropriate to the circumstances, occurs prior to removing access to prison facilities for health staff and state servants.

In the interim, the Director of Corrective Services, or their delegate, implement an internal process for consultation.

The Department of Justice did not support this recommendation in its response. The Department of Health did support it.

Conclusion

Our inspections highlighted a significant number of areas that require improvement in relation to mental and physical health care. The reports attached from Professor Norris and Dr Petch go into detail about issues we identified during the inspection and provide recommendations for improvement. The large number of recommendations provide a positive opportunity for TPS and CPHS to improve the quality of health care for a population that often has some of the poorest levels of health. A healthier prison population is likely to lead to a healthier environment for prisoners and for the staff that work there.

List of appendices

Adult health care inspection 2023

Appendix 1

Inspection standards

Office of the Custodial Inspector
Tasmania

Mental health care inspection standards

The Inspection Standards for Adult Custodial Centres in Tasmania can be viewed in their entirety on the Office of the Custodial Inspector website[1].The following standards were inspected during the mental health care inspection.

Mental health care

88 Prisons must make appropriate and adequate provision to meet the mental health care needs of prisoners.

88.1 An assessment of mental health should be made as part of the initial health screening required for all prisoners upon entry into custody, or if a more in-depth assessment is to be made, this should occur within the first 30 days of custody.

88.2 Prisoners who are suffering from a severe psychiatric illness should be assessed and transferred without delay so they may be managed by an appropriate tertiary or specialist health care facility rather than a prison. Prison diversion strategies to facilitate prisoners' care from correctional settings to the community services, as appropriate, should be in place.

88.3 Prisoners who exhibit particular behaviours, but who are not suffering from any diagnosable mental illness requiring treatment in a secure hospital, should be managed within special mental health facilities within the prison.

88.4 Prisoners who are otherwise suffering from mental illness or an intellectual disability should be provided with appropriate management and support services.

88.5 Mentally ill prisoners must never be punished for behaviour that is consequence of their illness.

88.6 Discharge planning systems must be in place to ensure that prisoners with a serious mental illness preparing for release have a care plan developed and documented to facilitate pathways or throughcare to community health services.

88.7 An adequate and effective psychological counselling service should be available to all prisoners.

88.8 Where a prisoner who enters or is released from prison is under medical or psychiatric treatment, the prison health service should make

[1] Office of the Custodial Inspector Tasmania 2018, *Standards & guidelines – Inspection Standards for Adult Custodial Centres in Tasmania*, Hobart, available: https://www.custodialinspector.tas.gov.au/standards_And_guidelines

arrangements with an appropriate agency for the continuation of such treatment after release, where appropriate.

88.9 Particular care should be taken to observe and provide support and counselling to remand prisoners that have mental health problems.

88.10 All staff who have contact with prisoners should receive some basic mental health awareness training. There should also be regular refresher training courses.

88.11 All nurses should have mental health training, and at least one nurse in each prison should be a registered mental health nurse.

88.12 Any General Practitioner providing inpatient health care must receive training or have experience in mental health care.

88.13 Prisons must seek to minimise the adverse impacts of imprisonment on the mental health of prisoners. This is particularly important with prisoners who are experiencing suicidal or self-harming ideation.

88.14 Correctional centre regimes should promote good mental health through purposeful activities, contact with family, health promotion, exercise and diet.

89 Prisons must have effective processes to detect and manage prisoners in crisis, particularly where they may self-harm. These processes should be multidisciplinary and should develop a therapeutic and supportive management regime for such prisoners.

89.1 Prisoners in crisis, particularly those at risk of self-harm, should be fully consulted and informed concerning any change to their management regime, including the criteria for a return to normal regime management. Consideration should be given to imposing the least restrictive regime commensurate to risk, including the use of 'buddy' arrangements with other prisoners.

89.2 All staff who have contact with prisoners should be trained in identifying self-harming ideation and suicide prevention.

89.3 Aboriginal prisoners should, when appropriate and practicable, have access to elders and community groups/organisations as a means of support.

89.4 Trauma and grief counselling should be offered where appropriate, and multidisciplinary mental health crisis teams should be available at all closed security prisons.

89.5 In the event of a self-harming incident, each prison must provide appropriate and readily accessible equipment for the severing of ligatures and apparatus for resuscitation.

89.6 In the event of a self-harming (or any other psychologically damaging) incident, appropriately skilled and trained counsellors should be made available to all affected prisoners and staff, and should conduct an impact assessment with a view to ensuring that adequate supports are made available for as long as necessary.

89.7 Any prisoners identified as being at high risk of self-harm or suicide should be visited daily and as frequently as is necessary

…

Physical health care and substance use management inspection standards

The following standards were inspected during the physical health care and substance use management inspection.

Physical Health

75 The type of health care available to all prisoners should reflect the health needs of the prison population.

75.1 The prison population, in particular its female and aged populous, has an abnormally high need for health services, therefore the screening and treatment provided should reflect these needs. In particular, prisoners have been found to have a disproportionately high prevalence of:

- chronic diseases such as diabetes, cardiac, respiratory and renal
- mental health disorders
- blood borne diseases, including hepatitis C
- alcohol, illicit drug and smoking disorders
- dental disorders.

76 Informed consent must be obtained from a prisoner for all health care or for the sharing of personal information with others involved in the prisoner's care.

76.1 Prisoners have a right to accurate and sufficiently detailed information about their individual health in a language and terms they can understand.

76.2 Consent to medical treatment must be voluntary and may be implied, oral or written. Verbal consent should be documented in patient files.

76.3 Where there is any doubt about a prisoners' ability to make a decision (e.g. if the prisoner is under the influence of a drug) obtaining consent should wait. If a prisoner has a guardian or a cognitive impairment, capacity to consent should be determined.

76.4 To enable informed decisions about their health care, prisoners should be advised of all available health services, treatment options and possible side-effects in a language and terms that are understandable to them.

76.5 Refusal of treatment must be documented and the implications of not receiving health treatment must be fully explained to the prisoner in a language and in terms that they understand.

76.6 Prisoners have the right to change their mind and withdraw consent at any point.

77 All prisoners should undergo a health examination by a qualified health professional within 24 hours after being received into prison.

77.1 All newly received prisoners should undergo a health examination within the first 24 hours. This should be followed up with a detailed clinical pathways assessment.

77.2 Following transfer from another prison, each prisoner's treatment plan should be reviewed by a health professional.

77.3 Waitlists and appointments must be transferred to the receiving prison.

77.4 Health files from previous sentences of imprisonment should be obtained.

77.5 Urgent health needs identified at reception must be attended to immediately.

77.6 Individual healthcare plans should be prepared, implemented, monitored and reviewed for each prisoner requiring physical or mental health care of a significant or on-going nature.

77.7 Relevant aspects of a prisoner's health care needs, such as any need for specialist care or treatment, should be accommodated in the Individual Management Plan, where appropriate and subject to proper privacy considerations. Healthcare plans should be regularly reviewed.

77.8 Where a prisoner's health needs will impact on the day-to-day management of a prisoner, appropriate information should forwarded to the relevant unit officer.

77.9 Detoxification policies should be available at all prisons.

78 Prison health services should be delivered in culturally appropriate ways.

78.1 Where possible, Aboriginal Health Workers should be available, particularly in prisons with high numbers of Aboriginal prisoners.

78.2 All health care workers, managers and professionals should have undergone Aboriginal cultural awareness training.

78.3 Health care must be provided in a culturally secure environment and manner to accommodate legitimate cultural rights, views, values and expectations of all prisoners.

78.4 Health care should be provided with respect for the privacy and dignity of persons receiving health care.

78.5 Prison health services should seek to establish a partnership with a local Aboriginal Medical Service to improve the cultural appropriateness of health services.

79 All prisoners should have access to a 24-hour, on-call, or stand-by primary health service that is a registered doctor or nurse.

79.1 Where a triage policy is used to assess to the health needs of prisoners, this should only be undertaken by an appropriately qualified health professional.

79.2 Triage policies should not operate to the disadvantage of prisoners who are illiterate, do not speak English, or who speak English as a second language.

79.3 All prisoners who have a medical complaint should be seen by a health professional as promptly as circumstances permit and at intervals appropriate to the diagnosis and prognosis in each case, according to good medical practice.

79.4 Each prisoner's treatment plan should be reviewed and regularly modified as necessary to meet changing health needs.

79.5 Where necessary, prisoners should be provided with support and counselling to assist them to manage their health issues.

79.6 Standard precautions for infection control must be applied.

79.7 Additional precautions may be needed for patients known or suspected to be infected or colonised with disease agents that cause infections in health care settings and that may not be contained by standard precautions alone.

79.8 Prisoners are not to be the subject of unreasonable medical or scientific research that may be injurious to their health. Reasonable research is defined as where informed consent is given by the prisoner and where approval has been given by a properly constituted health research ethics committee, such as according to National Health Medical Research Council Standards.

79.9 A health professional should advise the officer in charge of the prison whenever it is considered that a prisoner's physical or mental health has been, or will be, injuriously affected by continued imprisonment or by any condition of imprisonment, including where a prisoner is being held in separate confinement. The officer in charge of the prison should immediately make a written report of such advice available to the

appropriate senior officer with a view to effecting an immediate decision upon the advice that has been given.

80 Prisons that hold female prisoners must ensure appropriate health care services are available to meet the particular health needs of female prisoners.

80.1 A doctor of the same gender as the prisoner should be available where this is preferred.

80.2 Female prisoners should be educated about the benefit of pap smears. All women should have regular pap smears performed by a qualified practitioner with whom the woman is comfortable.

80.3 All women over 50 or with a family history of cancer should undergo a mammogram. Appropriate counselling and education should be included.

80.4 Pre-natal and post-natal treatment and accommodation should be made available to female prisoners, where practicable.

80.5 Arrangements are to be made for prisoners to give birth in a hospital outside the prison. If a child is born in prison, this fact should not be recorded on the birth certificate.

80.6 Prisons accommodating women should have 24-hour access to and liaison with appropriate hospital and community based obstetric and midwifery services.

80.7 Where practicable, there should be continuity of obstetric and or midwife staff providing care before, during and after birth.

80.8 Pregnant prisoners should be offered information and counselling by qualified counsellors regarding pregnancy and termination options.

80.9 A sterile pack for the emergency delivery of a baby, including instructions, should be available in the prison health centre.

80.10 Pregnant prisoners should have individual care plans developed as soon as a pregnancy is confirmed and the appropriate screening completed as soon as possible.

80.11 Pregnant prisoners should be considered eligible for some form of special provision with regard to gratuities while they are unable to participate in prison work.

81 Every prisoner is to have access to the services of specialist medical practitioners as well as psychiatric, dental, optical and radiological diagnostic services, on medical referral.

81.1 Prisoners should be referred to an external health provider where required treatment or services are not available within a prison or are more appropriately provided by others. Referral to such services should be based upon medical opinion and community health standards and not be unduly influenced by issues of security.

81.2 Prisoners should be able to receive treatment from private health professional provided there are reasonable clinical grounds for granting the application, they can meet the costs, and the request falls within the relevant statutory requirements.

81.3 A prisoner's dental care should be incorporated in his/her overall health care plan.

81.4 Acute dental first aid requirements must be met as soon as is reasonably possible.

81.5 Prisoners on dental (or other health) waiting lists should be informed of expected waiting times and any delays.

81.6 Prisoners in the last stages of their life should be considered for placement in a non-custodial setting prior to death and be managed having regard to their sentence, the community, victims, the intention of the sentencing court, the prisoner's family and the prisoner. Terminally ill prisoners must be provided with the care and treatment necessary to maintain their dignity and necessary comfort.

81.7 Prostheses and aides required by a prisoner must be made available on the recommendation of a health professional. Prisoners should be advised of the prison's liabilities in respect of prostheses maintenance and replacement and of his/her own personal responsibilities for their care.

81.8 Prosthesis should be provided, replaced or repaired by the prison where the need arises as a result of an accident, or medical condition and where an appropriately qualified health professional recommends the prisoner's general health would otherwise be seriously impaired.

81.9 A medical diet should be prescribed or modified by the Medical Officer

82 Prisoners who are isolated for health reasons shall be afforded all the rights and privileges that are accorded to other prisoners, wherever practicable, and so long as such rights and privileges do not jeopardise the health of others.

82.1 If a prisoner is found to have an infectious disease, the prisoner should be managed by health services to minimise the possibility of contamination of the prison.

82.2 The necessary infection control procedures must be implemented and the prison manager advised of any special requirements.

83 There must be a safe procedure for the distribution of medications to prisoners.

83.1 Over-the-counter medications to manage unexpected discomfort (such as headaches, influenza symptoms, toothache) should be readily available from reasonably accessible areas. Over the counter medications should be issued to prisoners in a manner that complies with general legal requirements and does not place any responsibility for clinical decisions on non-medical staff.

83.2 Where a prisoner was taking prescription medications upon being received into prison, and if recommended by the medical officer or registered nurse, the prisoner should continue to be prescribed this medication.

83.3 Prescribed medication should only cease on the recommendation of an appropriately qualified health professional.

83.4 Drugs that have a potential for abuse or dependency should only be prescribed when there is no alternative, and according to appropriate controls.

83.5 Prisoners with chronic and other medical conditions that require self-injection must be allowed to self-inject.

83.6 Prisoners with disabilities who require equipment for activities of daily living or chronic conditions must be allowed to keep the equipment in their cells with appropriate controls.

84 Health promotion and education should be delivered in the language of choice of the recipient and in a culturally appropriate manner to the individual and the setting.

84.1 Health promotion and health education must be evidence based.

84.2 Health prophylactics for harm minimisation (including condoms and dental dams) should be available in a confidential, non-judgemental context with appropriate education.

85 A health record file must be established for each prisoner at the first health assessment and all subsequent health contacts should be recorded in the file.

85.1 Health records must be stored in a secure place within the health centre.

85.2 The confidentiality of medical information must be maintained to preserve each prisoner's individual right to privacy. However, medical information may be provided in certain circumstances on a 'need to know' basis: with the consent of the prisoner, or in the interest of the prisoner's welfare, or where to maintain confidentiality may jeopardise the safety of others or the good order and security of the prison.

85.3 Upon notification of transfer of the prisoner to another prison, the relevant health file should be updated and forwarded with the prisoner.

85.4 Where necessary on release from prison, each prisoner should be given a summary of his/her health status, referral to the community health care provider of the prisoner's choice, and a medical certificate supporting a sickness benefit application.

86 Health centre staff should be appropriately qualified.

86.1 Health centre staff should receive adequate regular training and development to keep them abreast of new developments.

86.2 Health centre staff should receive training in specific health issues relevant to the prisoner cohort.

87 Health Centre staff should be consulted on all areas of the prison regime relevant to prisoner health.

87.1 Health centre staff should be consulted with regard to fitness and recreation opportunities for prisoners.

87.2 Health centre staff should be consulted regarding the appropriateness of provisions within the kitchen and canteen.

87.3 Health centre staff and the services they provide should be integrated into the wider correctional centre rehabilitation effort.

Management and Treatment of Substance Abuse

93 Prisons should have effective mechanisms to reduce the demand for drugs.

93.1 A range of culturally appropriate, evidence-based, externally-evaluated drug and alcohol programs should be available for prisoners to match demand identified through the application of validated assessment of instruments.

93.2 Where practicable, prisons should provide incentives for prisoners to apply for drug-free units.

94 Prisons should have effective mechanisms to treat and reduce the harm caused by drug use.

94.1 All prisoners should have the opportunity to undertake a basic substance use education program. This should include information about the side effects of drug use and the support services that are available.

94.2 Substance dependent prisoners should receive prompt, competent, professional help in the treatment of withdrawal.

94.3 Differential sanctions, based on the varying harm caused by the drugs used by prisoners, should be applied and integrated with treatment.

94.4 Prisoners needing to recover from chronic or acute drug addiction require effective treatment, often with medication followed by management of the problem over time. Post withdrawal interventions and post release pathways should be in place. Poly-substance abuse pathways should also be assisted with pathways support.

94.5 Where appropriate, replacement pharmacotherapy should be available, according to strict eligibility criteria and in conjunction with a management plan that ensures an appropriate transition to a joined–up community treatment program on release. Pre and post release support should facilitate access to a range of drug and alcohol, health and welfare services.

94.6 Processes should be in place to ensure regular review of treatment occurs for all opioid substitution therapy prisoners.

94.7 Prisoners with substance related needs should be given access to a range of appropriate activities and regimes (including drug free incentives) that support change and challenge offending behaviour.

94.8 At each prison (excluding the reception prisons) partnerships should be developed with local drug rehabilitation, counselling and education organisations.

95 Prisoners with alcohol misuse problems should have access to appropriate treatment and support.

95.1 Initial health assessments should identify those who are physically dependant on alcohol and require detoxification, as well as those who, although not physically dependant, are at serious risk of harm. Intervention should be recommended commensurate with the prisoners assessed level of need.

95.2 Intervention for those at risk of withdrawal should begin as soon as possible. The detoxification process should be clinically supervised and appropriate support should be offered to the prisoner.

95.3 Assessment for offending behaviour programs should identify whether alcohol misuse is a significant factor in previous or current offending and intervention supplied accordingly.

95.4 Accredited alcohol treatment programs and interventions should be provided to prisoners at risk from alcohol misuse. These should seek to address the underlying causes of a prisoner's drinking behaviour.

95.5 Culturally appropriate alcohol-specific support groups and individual support should be available to prisoners.

95.6 Where alcohol misuse forms part of poly-drug misuse, prisoners should be offered both structured substance misuse treatment interventions and specific alcohol interventions to offer a holistic approach.

95.7 Where possible, links should be made with community organisations to provide evidence based alcohol intervention. With prisoner consent, the prison should liaise with these agencies to ensure appropriate information sharing and joint planning to ensure continuity of care upon release.

95.8 All prisoners who have engaged in alcohol treatment should undergo pre-release intervention and be supported in developing appropriate community links for continuity of treatment and support where appropriate.

95.9 Training and support structures should be offered to staff to encourage them to reflect on their own attitudes, knowledge and beliefs about alcohol and enable them to work effectively with alcohol misusing prisoners.

96 All prisoners should be offered alcohol education programs to raise awareness of the potential harms and to encourage safe and responsible drinking based on informed choices. Prisoners with alcohol misuse problems should have access to appropriate treatment and support.

96.1 Education, treatment and intervention programs should be tailored to suit the cultural and linguistic needs of the target group.

96.2 Families of prisoners should be provided with information about alcohol dependence, withdrawal and support.

97 In the interests of improved health, prisoners and staff are prohibited from smoking.

97.1 Recognising that many staff and prisoners already smoke, support (including pharmacotherapy) should be made available for people withdrawing from tobacco addiction, particularly prisoners newly received into prison.

Adult health care inspection 2023

Appendix 2

Report by Professor Kimberly Norris – mental health care

Office of the Custodial Inspector
Tasmania

UNIVERSITY OF TASMANIA

School of Psychological Sciences

Evaluation of Mental Health Services in Tasmanian Custodial Contexts

Final Report

August 2022

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Table of Contents

List of Key Terms, Acronyms and Abbreviations

Key Terms

Mental Health

Mental health is a broad term referring to a person's capacity to successfully manage the everyday stressors and challenges of life, engage in meaningful personal/ social relationships, experience satisfaction and productivity across multiple life domains (including work and non-work roles) and experience a sense of meaning and purpose[1]. Mental health fluctuates over time in response to internal and external challenges.

Mental Illness

As per the Mental Health Act (2013) Tasmania[2], mental illness refers to temporary, repeated or chronic experiences of serious impairment in thoughts, mood, cognition, perception or decision making.

Wellbeing

Wellbeing refers to a complex combination of factors across a person's physical, mental, emotional and social life domains. In this way, wellbeing is distinct from, but related to, mental health. Some researchers have conceptualised wellbeing as how and individual feels about themselves, and their life[3].

Therapeutic Climate and Therapeutic Culture

Although the terms therapeutic culture and therapeutic climate are terms that are frequently used interchangeably[4], there are differences between these constructs. Therapeutic culture can be understood as an overall organisational philosophy that influences attitudes, perceptions, motivations, goals and behaviours[5] as they relate to offender rehabilitation and mental health treatment. In contrast, therapeutic climate

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[1] Department of Health and Aged Care 2022, *About Mental Health.* Australian Government, <https://www.health.gov.au/health-topics/mental-health-and-suicide-prevention/about-mental-health>.
[2] Mental Health Act 2013 (Tas). <https://www.legislation.tas.gov.au/view/whole/html/inforce/current/act-2013-002>.
[3] Better Health Channel n.d, *Wellbeing*, Department of Health, Victoria State Government, <https://www.betterhealth.vic.gov.au/health/healthyliving/wellbeing>.
[4] Parker, CP, Baltes, BB, Young, SA, Huff, JW, Altmann, RA, Lacost, HA & Roberts, JE 2003, 'Relationships between psychological climate perceptions and work outcomes: A meta-analytic review', *Journal of Organizational Behavior*, vol. 24, no. 4, pp. 389-416. DOI: 10.1002/job.198
[5] Melnick, G, Ulaszek, WR, Lin, H-J & Wexler, HK 2009, 'When goals diverge: Staff consensus and the organizational climate', *Drug and Alcohol Dependence*, vol. 103, suppl. 1, pp. S17-S22. DOI: 10.1016/j.drugalcdep.2008.10.023

refers to perceptions of an organisation at the operational level and is perceived to be more malleable than culture and can serve as a precursor or “ground up” approach for cultural change[6].

Therapeutic Jurisprudence

Therapeutic jurisprudence refers to the "study of the role of the law as a therapeutic agent"[7], both acknowledging and focusing on the impact of legal processes on mental health and psychological wellbeing. In doing so, this approach recognises the law and legal proceedings as a ‘social force’ that influences thinking, feeling, and behaviour and encourages a ‘therapeutic’ approach to the law and legal proceedings that recognises the role of psychological factors whilst protective justice and due process. In practical terms, this indicates that a person’s psychological presentation and needs are considered in the application of the law, including sentencing and rehabilitation decisions.

Mental Health Literacy

Mental health literacy is a term that refers to an individual’s understanding of how to obtain and maintain positive mental health; understanding of mental disorders and their treatments; engage in active non-stigmatisation of mental disorders; skills in improving their own mental health; and knowing when and where to seek help[8].

Evidence Informed and Evidence Based Interventions

All mental health interventions should be based on available evidence to maximise efficacy and ensure fitness for purpose[9]. Evidence-based practice/interventions refers to a highly structured approach to decision making using the best available evidence to guide treatment decision making, taking into account the client’s individual needs. Evidence-informed practice/interventions integrate professional judgement with available research evidence regarding treatment efficacy, and is a less objective and structured approach to clinical treatment decision making.

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[6] Taxman, FS, Cropsey, KL, Melnick, G & Perdoni, ML 2008, ‘COD services in community correctional settings: An examination of organizational factors that affect service delivery’, *Behavioral Sciences and the Law*, vol. 26, no. 4, pp. 435-455. DOI: 10.1002/bsl.830

[7] Wexler, DB & Winick, BJ 1996, ‘Law in therapeutic key: Developments in therapeutic jurisprudence’. *Current Issues in Criminal Justice,* vol. 8, no. 3, pp.337-340.

[8] Kutcher, S, Wei, Y & Coniglio, C 2016, ‘Mental Health Literacy: Past, Present, and Future’, *Canadian Journal of Psychiatry*, vol. 61, no. 3, pp. 154-158. DOI: 10.1177/0706743715616609

[9] Melnyk, BM & Newhouse, R 2014, ‘Evidence-based practice versus evidence-informed practice: a debate that could stall forward momentum in improving healthcare quality, safety, patient outcomes, and costs’, *Worldviews on Evidence-Based Nursing*, vol. 11, no. 6, pp. 347-349. DOI: 10.1111/wvn.12070

Acronyms

AYDC	Ashley Youth Detention Centre
BDP	Behavioural Development Program
CPHS	Correctional Primary Health Services
CSU	Crisis Support Unit
EAP	Employee Assistance Program
EUE	Extreme and Unusual Environment(s)
HRP	Hobart Reception Prison
HRAT	High Risk Assessment Team
LRP	Launceston Reception Prison
MATES	Peer support program for Tasmania Prison Service Staff; Affiliated with Frontline Mind
MDT	Multidisciplinary Team
MHWP	Mary Hutchinson Women's Prison
MOU	Memorandum of Understanding
RPC	Risdon Prison Complex
SASH	Suicide and Self-Harm
SRC	Southern Remand Centre
TPS	Tasmania Prison Service
TSU	Therapeutic Services Unit

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I gratefully acknowledge the support of Custodial Inspectorate Staff Belinda Chamley, Kirsty Bower, and staff at Custodial settings in Tasmania who engaged with this evaluation by providing access to data and information regarding mental health in custodial contexts that led to this report. I also gratefully acknowledge the participation and support of Sam Christensen from the Ombudsman's Office in this review process, and acknowledge the financial support provided by the Custodial Inspectorate to undertake this evaluation.

I further acknowledge the traditional owners of the lands on which this evaluation took place, paying respect to elders past, present and emerging and recognising the importance of Aboriginal and Torres Strait Islander knowledge in supporting the health and wellbeing of all Aboriginal and Torres Strait Islander people.

The Author

Kimberley Norris (PhD) is a Professor of Psychological Sciences and a Clinical Psychologist within the School of Psychological Sciences, College of Health and Medicine, at the University of Tasmania.

Professor Norris works across academic, research and clinical practice settings. Her overarching research and academic interests are focused on maximising human health, wellbeing and performance in both normal and extreme environments. She has particular expertise in the impacts of isolation and confinement on mental health and has researched mental health within offending populations and custodial contexts. Further, she has extensive experience researching and providing consultancy services to enhance mental health within organisational contexts.

Executive Summary

Background

This report is designed to be read in conjunction with the report of assessment (2022) completed by the Custodial Inspectorate against each of the mental health standards required of Custodial settings in Tasmania.

An important consideration that underpins all data and interpretations contained within this report regards the unique circumstances that custodial contexts place on prisoners and staff. The nature of the physical, social and psychological environment within these contexts increases the risk of exposure to a range of situations - including potentially traumatic events - that substantially differ from routine environments in which most people live, recreate and work. For these reasons, custodial contexts are inherently challenging and can be categorised as extreme and unusual environments.

Extreme and unusual environments (EUES) are defined along four key parameters - physical, social, technological and psychological. An overview of the relevance of each of the four parameters within custodial contexts is detailed below:

Physical environment: Prisoners (in most instances) are physically separated from friends and family. They are also isolated from non-incarcerated community members. They have limited influence over the physical environment as a result of their incarceration. Further, by definition prisoners are confined within a limited geographical area.

Social environment: Prisoners are removed from pre-existing sources of social support as a result of their incarceration and have very limited control over their social interactions. They are housed with individuals not of their own choosing and have an overarching daily structure/routine imposed as a result of their incarceration. When visited by family and friends all interactions are overseen by custodial staff.

Technological environment: Unlike experiences of non-incarcerated individuals in Tasmania, prisoners in custodial contexts have limited control over access to communication technologies. Access to these technologies is restricted to certain times of each day, and with limited privacy.

Psychological environment: Prisoners are residing in an environment in which they exercise limited control and freedoms. The cumulation of physical, social and

technological impacts increase the likelihood of negative psychological health and wellbeing[10].

Despite a predominant focus on the negative impacts of EUES within the research literature, it is also recognised that positive outcomes are also associated with experiencing EUES. These positive outcomes include, but are not limited to, increased awareness of personal values; greater interpersonal tolerance; identity exploration; and development of new perspectives[11]. It was evident within the context of this evaluation that there are positive experiences pertaining to mental health within custodial contexts, and commendations have been made in this regard.

Although an environment does not need to meet all four parameters to be categorised as an EUE, the domains do interact to influence each other. Importantly, researchers have consistently demonstrated that the psychological parameters of an EUE have a disproportionate impact on the mental health and wellbeing of individuals and groups living and working within them - hence the need for focused attention on mental health within custodial contexts in Tasmania.

The Current Mental Health Evaluation

In June 2022, the Custodial Inspectorate undertook an evaluation of mental health services within Custodial contexts in Tasmania. Professor Norris attended these inspections as an independent expert in mental health.

The objectives of this report are to:

1. Identify instances of best practice in supporting the mental health needs of those living and working within custodial contexts in Tasmania
2. Identify opportunities to further enhance mental health services offered within Tasmanian custodial contexts
3. Inform recommendations based on the above

[10] Norris, K 2010, *Breaking the ice: Developing a model of expeditioner and partner adaptation to Antarctic employment,* PhD thesis (unpublished), University of Tasmania.
[11] Norris, K 2010, *Breaking the ice: Developing a model of expeditioner and partner adaptation to Antarctic employment,* PhD thesis (unpublished), University of Tasmania.

To achieve these objectives, the author attended each custodial site with the Custodial Inspectorate and obtained information regarding mental health needs and services from the following sources:

- Written submission tendered by each custodial site in response to the mental health standards
- Interviews with correctional staff at each custodial setting
- Interviews with health/mental health/therapeutic staff at each custodial setting
- Interviews with residents/offenders in adult custodial settings
- Previous reports of mental health services provided in Tasmanian custodial settings

Custodial Settings in Tasmania

As listed below, there are a number of custodial contexts located in Tasmania that were the focus of this evaluation.

1. Ashley Youth Detention Centre
2. Launceston Reception Prison
3. Hobart Reception Prison
4. Risdon Prison Complex (includes a medium and a maximum security precinct)
5. Ron Barwick Prison
6. Mary Hutchinson Women's Prison

A brief overview of the nature of each facility prefaces the related commendations and recommendations contained within this report. Note that as the Wilfred Lopes Centre is operated by the Tasmanian Health Service, rather than the Tasmanian Prison Service, it was outside scope of the current evaluation[12].

Sources of Data

A range of data was obtained in the process of constructing this report and associated commendations and recommendations. These data included publicly available reports, the previous inspectorate report, data from the Australian Institute of Health and Welfare, empirical research, interviews with residents at each adult custodial site, and staff (correctional and non-correctional) at each custodial site. To provide an environment in which those interviewed were able to speak openly about their

[12] ***Note:*** the Wilfred Lopes Centre is operated by the Tasmanian Health Service, rather than the Tasmanian Prison Service. As such it was outside scope of the current evaluation.

experiences, a decision was made to anonymise participation for the purposes of the report. For this reason, information is not attributed to any individual staff member or resident, and no direct quotes have been included in this report unless this was already a matter of public record.

Limitations of the Evaluation

Importantly, the data and resultant analyses that have informed commendations and recommendations have some inherent limitations. These limitations should be considered in the context of interpreting data and recommendations.

An important consideration is that no child/adolescent residents of Ashley Youth Detention Centre (AYDC) participated in the interviews. This increases the likelihood that data derived from this process may not accurately reflect the lived experience of residents at AYDC and may be more strongly influenced by non-generalisable results - i.e., reflect the experience of individuals, and not the cohort of interest. It is also noted that at the time of the evaluation there was focused media attention on historical and ongoing allegations of abuse perpetrated towards AYDC residents, and that this was negatively impacting residents and staff alike in this custodial setting. It is therefore possible that data may have differed if obtained at a different point in time.

A further limitation relates to the period in which this evaluation occurred. A majority of custodial sites were anticipating relocation, redevelopments, and were experiencing substantial change when visited. As such, it is plausible that some of the recommendations contained within the current report may already be a focus of future developments for the relevant site or may change once these planned redevelopments/relocations have occurred. As such, the author reserves the right to reconsider their opinions should new information or data become available.

Report Findings

Detailed consideration of the data obtained in the course of this evaluation led to a series of findings, a brief summary of which is detailed below.

All participants involved in this evaluation were highly collegial and collaborative toward the Custodial Inspectorate process and are thanked for their time and efforts in this regard. I also extend praise towards the observed knowledge and commitment to maximising mental health in custodial contexts.

Overarchingly, all obtained data indicated improvements in, or plans towards improving, mental health service standards since the last mental health evaluation conducted by the Custodial Inspectorate. A primary inhibitor in making needed progress regarding mental health service provision within custodial settings in Tasmania pertains to resourcing. Across all settings there was awareness of needed changes, and in most contexts plans to achieve these changes, however all sites were constrained by insufficient staffing and infrastructure. Insufficient resourcing poses multiple risks to supporting the mental health needs of residents and staff within custodial contexts, pertaining to both the identified shortcomings as well as the negative impacts of perceived hopelessness and helplessness that can emerge when identified limitations remain unaddressed. It is recognised that some efforts to addressing these resourcing issues have been attempted, however given the ongoing difficulties with recruitment and retention of staff - alongside infrastructure constraints - it is evident that new, innovative and fit-for-purpose strategies need to be engaged.

In collation and interpretation of data for this report, a series of commendations and recommendations have been identified. The commendations identify areas of strength that can be consolidated and built upon to further enhance mental health service provision in custodial contexts in Tasmania. The recommendations provide strategies to further enhance the provision of services that address mental health needs within custodial settings in Tasmania. These commendations and recommendations pertain to all custodial contexts in Tasmania unless otherwise specified.

Commendations

Commendation 1	All staff engaged in this evaluation process reported and were observed to provide high levels of collegial support to one another, which creates an environment of psychological safety to protect the mental health of staff.	
Commendation 2	AYDC staff are highly engaged and resident focused	Page 76
Commendation 3	AYDC staff are engaging in practices designed to provide a more therapeutic and rehabilitative context for residents	Page 89
Commendation 4	Decisions regarding SASH accommodations are made collaboratively between correctional staff, health staff, and prisoners (where appropriate)	Page 105
Commendation 5	Increasing access to fit-for-purpose mental health supports	Page 110
Commendation 6	Prioritisation of proactive mental health initiatives to support the mental health needs of staff have been implemented with evidence of uptake by staff	Page 111
Commendation 7	Improved staff rostering to support positive mental health	Page 112
Commendation 8	TPS staff involved in this evaluation demonstrated a high level of commitment to supporting the mental health needs of	Page 113

	offenders currently housed in custodial settings in Tasmania	
Commendation 9	The level of enthusiasm, passion, knowledge of criminogenic needs and commitment of all staff to addressing the mental health needs of prisoners housed within RPC	Page 117
Commendation 10	Staff are commended on their efforts to develop a more therapeutic climate to support prisoner recovery	Page 120

Recommendations

Ashley Youth Detention Centre

Ashley Youth Detention Centre

The Ashley Youth Detention Centre (AYDC; formerly known [1926-1999] as the Ashley Home for Boys) is focused on delivery of custodial services for children aged 10-18 years who are on remand or subject to custodial sentence in Tasmania. It is the sole provider of these services in Tasmania. At the time of evaluation, AYDC was providing accommodation for 10 adolescents. Prior to the redevelopments underway at the time of evaluation, AYDC provided accommodation for up to 51 young people in four different units, Bronte, Huon, Franklin, and Liffey. Ashley School, run by the Education Department, opened on the site of the Detention Centre in 2003 and continues to offer educational services to residents within AYDC.

Detailed below are a range of recommendations to address a number of existing limitations relating to mental health within the AYDC context. However, prior to presenting these recommendations it is important to acknowledge and commend the dedication of staff within this setting. All staff within AYDC who participated in this evaluation demonstrated a high level of knowledge, engagement and desire to support the mental health and psychosocial needs of young people residing in AYDC.

Commendation 2

AYDC staff are highly engaged and resident focused

Change Management Processes

In 2021 the then Premier of Tasmania, Peter Gutwein, advised that AYDC would be closed[13]. This decision was based on evaluations which determined the existing service model and its resources to be inadequate in meeting the needs of residents. At the time of this report, a date for this closure had not been confirmed nor had a plan for alternative accommodation for children and young people on remand or subject to custodial sentences been made publicly available. In the Premier's statement released about the closure of AYDC it is stated that "Importantly we will consult with the Custodial Inspector and the Commissioner for Children and Young People on the best

[13]Gutwein, P, Premier, Minister for Children and Youth 2021, *Ashley Youth Detention Centre to Close, media release,* Department of Premier and Cabinet, 9 September, <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/ashley_youth_detention_centre_to_close>.

model and approach to support those most at risk during the transition period"[14]. At this time the affected residents and staff of AYDC have not been provided support relating to this issue, and mental health is suffering as a result. The reported absence of support at this time may be due to the transition period being narrowly defined as the physical transition between locations. However, as evidenced by statements from AYDC staff, it appears that the time leading up to this transition will exceed the physical transition itself and as such needs to be a focus of proactive prevention and intervention to support the mental health needs of residents and staff.

This ongoing ambiguity regarding the future of the service is having a substantial negative impact on the mental health and wellbeing of residents and staff alike with evidence of anxiety, feelings of hopelessness and helplessness. The impacts of intolerance of uncertainty were also evident through these discussions[15]. Prolonged experiences of the above symptoms can increase the likelihood of developing burnout and compassion fatigue[16], as well as clinically diagnosable anxiety and depressive disorders, along with adjustment disorder[17].

The above noted uncertainty regarding the future of the AYDC leads to the first of a series of recommendations specific to this custodial setting.

Recommendation 1

Develop and implement change management processes to support staff and residents until the proposed closure/redevelopment of Ashley Youth Detention Centre

[14] Commissioner for Children and Young People Tasmania 2021, *Ashley Youth Detention Centre*, media release, Commissioner for Children and Young People Tasmania, September, <https://www.childcomm.tas.gov.au/wp-content/uploads/CCYP-Media-AYDC-091021.pdf >.

[15] Dugas, MJ, Buhr, K & Ladouceur, R 2004, 'The role of intolerance of uncertainty in etiology and maintenance', in RG Heimberg, CL Turk, & DS Mennin (eds), *Generalized anxiety disorder: Advances in research and practice*, The Guilford Press, pp. 143-163.

[16] Bell, S, Hopkin, G & Forrester, A 2019, 'Exposure to traumatic events and the experience of burnout, compassion fatigue and compassion satisfaction among prison mental health staff: An exploratory survey', *Issues in Mental Health Nursing*, vol. 40, No. 4, pp. 304-309. DOI: 10.1080/01612840.2018.1534911

[17] American Psychiatric Association 2022, *Diagnostic and statistical manual of mental disorders*, 5th edn, text revision, American Psychiatric Association.

The importance of appropriate change management processes in supporting staff and residents through the transition period as the AYDC service delivery framework and location cannot be underestimated. There is an extensive body of literature that provides guidance on how to effectively support stakeholders through periods of organisational change[18]. Of particular relevance to the AYDC context is that change management must span the entire change process from preparation (pre-change) through the transitional period to the post-change phase. Specifically, a framework and transitional supports need to be implemented now to provide stability, psychological safety, and a level of certainty until plans regarding the future of AYDC have been finalised. In the absence of these transitional supports the mental health and wellbeing of residents and staff will continue to be negatively impacted and exacerbated. In turn, these declines in mental health will require greater levels of intervention and may reduce the capacity of staff to provide for the mental health needs of residents as burnout reduces the emotional availability that can be directed towards others[19]. Ultimately, this results in a cycle of mental ill health for staff and residents alike.

Impacts of Abuse Allegations on Staff and Residents

In tandem with the negative impacts of uncertainty regarding future operations are the impacts of negative media attention and ongoing investigations into allegations of historical and contemporary abuse towards residents. Investigations into these allegations were ongoing at the time this report was submitted, the negative impacts of which were reported by all individuals who participated in interviews for this setting. It was reported that staff were able to access an Employee Assistance Program (EAP) or private practitioners for support if they were being impacted by the current media focus. The EAP services were reported to be lacking a specific knowledge of working in custodial settings (particularly child and adolescent custodial settings), and as such perceived to be less able to provide the support desired by AYDC staff. This feedback regarding the need for organisational specificity/knowledge, of EAP providers is not

[18] For example, see:
Kennett-Hansel, PA & Payne, DM 2018, 'Guiding principles for ethical change management', *Journal of Business and Management*, vol. 24, no. 2, pp. 19-45. DOI: 10.6347/JBM.201809_24(2).0002
Heckelman, W 2017, 'Five critical principles to guide organisational change', *OD Practitioner*, vol. 49, no. 4, pp.13-21.

[19] Samra, R 2018, 'Empathy and burnout in medicine - acknowledging risks and opportunities', *Journal of General Internal Medicine*, vol. 33, no. 7, pp. 991-993. DOI: 10.1007/s11606-018-4443-5

unique to custodial contexts. However, at this time it comprises the utility of supports available to staff and is therefore being underutilised.

Recommendation 2
Employee Assistance Program (EAP) providers are specifically trained to understand and support staff working within custodial contexts

As an extension of this recommendation, it is a requirement that the EAP provider or another mental health professional provide a framework regarding the organisational responses to the current media focus and associated allegations of abuse perpetrated towards residents. This is a complex and multifaceted situation in which the importance of ensuring a thorough and objective investigation into allegations occurs whilst validating and supporting all staff. At present staff report feelings of invalidation, and a lack of support due to a perceived absence of an organisational response to these accusations that recognises and addresses the psychological impacts on staff and residents.

Recommendation 3
The Ashley Youth Detention Centre EAP provider or another mental health professional provide a framework regarding the organisational responses to the current media focus and associated allegations of abuse perpetrated towards residents

Given the existing staffing shortages (detailed further below) there is likely limited scope for AYDC staff to provide extensive input into the training needs of the EAP provider. The gold-standard approach to addressing the identified training needs would involve a mixed-methods approach in which an extensive review of existing research literature, stakeholder interviews, and psychological assessments are integrated to identify a framework to guide evidence-based practice for provision of mental health support to AYDC/custodial staff. Access to the research units within the broader

Tasmanian custodial context (such as that within the Risdon Prison Complex (RPC)) may be of assistance in this regard, although it is noted that this unit is currently under-resourced and likely would not have capacity to assist. As such, it is recommended that as an interim measure information be sought from other jurisdictions regarding their EAP providers and their organisational fit.

Recommendation 4
As an interim measure, information be sought from other jurisdictions regarding their EAP providers and their organisational fit

A further consideration are the impacts of allegations on youth residents. It was reported that residents were aware of the allegations and reported feeling unsafe due to a perceived risk of abuse which can elicit fear-based affective and behavioural responses, which may further compound existing anxiety conditions or trauma histories. It was also reported that some residents alleged that friends and family had been subject to abuse whilst incarcerated within AYDC, increasing the risk of intergenerational trauma responses. In either context - either fear or trauma - a young person's capacity to engage with adaptive behaviour can be reduced, increasing risk of maladaptive behaviour and associated consequences within the custodial context[20]. Given the current staffing issues (detailed later in this report), it appears that AYDC are not well placed to address the increased distress and fear/trauma responses that residents may experience.

Staffing

The present staffing levels at AYDC pose a significant risk to the mental health and wellbeing of residents and staff. A specific example of the staffing shortages that was noted by multiple staff (although emphasised by all that this is not the only example of such shortages) is that at present there is one youth worker who is tasked with managing exit planning requirements for all residents.

[20] Moreland-Capuia, A 2019. 'Trauma Informed: The Intersection of Fear, Trauma, Aggression, and a Path to Healing', in Moreland-Capuia, A, *Training for Change,* Springer Cham, New York City, pp. 59-84. DOI:10.1007/978-3-030-19208-2_3

It is acknowledged that some staff are currently on a mandated leave of absence due to ongoing investigations into allegations of misconduct in their role. However, at present these roles have not been backfilled and cannot be readvertised as the roles themselves remain occupied. As a result, remaining staff are working large amounts of overtime to try and limit flow-on effects to residents. Despite these efforts it is noted that there are rarely sufficient staff to support residents when attending court proceedings, and that excursions outside the facility have been restricted due to limited staffing. These opportunities to engage in activities outside AYDC are an important aspect of mental health as well as a motivator for positive behaviour within AYDC that can support the development of new neural networks that underpin further prosocial and adaptive behaviour following release[21]. These staffing shortages have also led to repeated instances of lockdowns and long periods of isolation for residents (discussed in greater detail later in this report).

However, the increased work hours increase the risk of burnout to staff and reportedly has resulted in increased stress leave, workers compensation claims, and sick leave (in addition to leave required due to COVID-19 isolation requirements). In turn, decreased staffing has resulted in lockdowns for residents in which they are confined to their rooms for large periods of each day unable to interact with others, be they peers or staff. The impacts of isolation and confinement on mental health have been well documented in both custodial [22] and non-custodial [23] contexts, including specific impacts for children and adolescents. The impacts of isolation and confinement differ to some degree across the lifespan, due to differing developmental processes at the cognitive, affective and behavioural levels. Relevant to the AYDC context is evidence that psychosocial development, including key components of identity development, is impaired when children and adolescents experience social isolation[24]. Further, social isolation at AYDC limits the opportunity of residents to practice more adaptive

[21] Jetha, MK & Segalowitz, SJ 2012. *Adolescent brain development: Implications for behaviour*. 1st edn, Academic Press, Amsterdam.
[22] Kupers, TA 2008, 'What to do with the survivors? Coping with the long-term effects of isolated confinement', *Criminal Justice and Behaviour*, vol. 35, no. 8, pp. 1005-1016. DOI: 10.1177/009385480831859
[23] Bartone, PT, Krueger, GP & Bartone, JV 2018, 'Individual differences in adaptability to isolated, confined and extreme environments', *Aerospace Medicine and Human Performance*, vol. 89, no. 6, pp. 536-546. DOI: 10.3357/AMHP.4951.2018
[24] Imran, N, Zeshan, M & Pervaiz, Z 2020, 'Mental health considerations for children and adolescents in COVID-19 pandemic', *Pakistan Journal of Medical Sciences*, vol. 36, COVID19-S4, pp. S67-S72. DOI: 10.12669/pjms.36.COVID19-S4.2759

behaviours that are required to facilitate long-term positive behaviour change that can support their success following release.

Recommendation 5
Urgently increase Ashley Youth Detention Centre staffing resources to protect residents and staff

It is acknowledged that outside the context of staffing shortages AYDC residents can be confined to their room in isolation due to behavioural concerns that pose a risk of harm to themselves or others. The current policy stipulates that Operational Coordinators can isolate a resident for up to 30 minutes; the AYDC Manager can impose isolation of a resident for up to three (3) hours; the AYDC Director can authorise a further three (3) hours if they deem this to be appropriate. Periods of isolation that extend beyond six (6) hours need to be approved by the Departmental Secretary. The existing policy makes clear that the use of isolation and confinement in these instances is solely for the protection of the self and others. There was no documentation to indicate that isolation and confinement was being used regularly for this purpose. However, as noted above, due to staffing shortages it was reported through email correspondence to the Inspectorate by senior AYDC management that residents were being isolated within their rooms for up to 21 hours each day which poses significant risk to the mental health and wellbeing of residents, as well as limiting their opportunity to develop adaptive prosocial behaviours. In doing so, the risk of reoffending for those currently residing at AYDC is increased.

It is evident from discussions with staff that difficulties recruiting to AYDC positions is due, at least in part, to the impending closure and lack of information regarding whether existing positions will continue in the new model. This lack of employment stability reduces the appeal of working in this context and is also undermining existing staff intentions to remain working at AYDC. This further emphasises the recommendation that transition planning be expanded to provide clear pathways of employment and to encompass the entire transition process from preparation (pre-transitional) through transition to the post-transitional phase. Further, given the reported difficulties in recruiting to positions in AYDC, it may be prudent to consider alternative employment models such as conjoint appointments with Child and Adolescent Mental Health

Services, headspace, or as an interim measure engage graduate internships and collaborations with training providers such as Social Work, Nursing, Medicine, Counselling, and Psychology at the University of Tasmania.

A further recommendation relating to staffing recruitment and retention is to review the Award Wages to ensure that these are competitive to the external market, as multiple staff commented on the low wages afforded to AYDC staff - particularly those with mental health training - which leads to a loss of both high-quality applicants and retention of existing staff. Further, engaging strategies and incentives to make AYDC an employer of choice is also warranted, particularly given the wide-scale negative media coverage which may be undermining recruitment efforts. These efforts will need to persist beyond the relocation and new operating model for provision of custodial services to children and youth in Tasmania, as the stigma associated with the existing model will not resolve through applying the new model alone.

Recommendation 6
Review Award Wages to ensure that these are competitive to the external market

Another staffing component that needs consideration is that at present there are insufficient staff to actively engage in contingency and succession planning. The difficulty in attracting new staff to the facility largely prohibits a formalised handover process between incoming and outgoing staff, as well as limits opportunities for robust formalised onboarding and outboarding procedures. As a result, large amounts of organisational knowledge are lost with each employee leaving AYDC. Given that this knowledge also extends to relationships with external service providers, the implications extend beyond the immediate short-term impacts associated with onboarding of new staff to longer-term capacity to engage required supports for residents. The absence of succession planning and capacity for formalised onboarding and outboarding processes have been reported to impact resident experiences, particularly as they relate to exit planning and ensuring that residents are going to be

well supported as they re-engage with the broader community - factors that are demonstrated to impact risk of recidivism[25].

Mental Health Professionals

Staff within AYDC were not aware of a mechanism for recording deidentified mental health presentations and needs of AYDC residents to allow for evidence-based planning of mental health intervention needs. Access to these types of records would not require sharing of confidential information but instead serve as a high-level database to inform mental health training and resourcing. Access to a centralised data repository with stratified levels of access depending on staff role would allow for better ability to coordinate resident mental health needs, as well as facilitate communication regarding through care and prepare for situations in which young people with pre-existing mental health needs re-engage with AYDC.

Recommendation 7

Development of a structured, standardised and integrated system to assist in record management for offender mental health data.

At present a majority of formalised mental health interventions are engaged through external services providers. It was reported that AYDC has been operating without an onsite psychologist since November 2021. The psychologist ceased their employment following the announcement of the closure of AYDC and perceived loss of career stability, again emphasising the importance of recommendations regarding organisational change processes. Staff identified a need for an onsite psychologist to facilitate ease of access for residents (particularly for cognitive and other forms of assessment that cannot be conducted via telehealth, as well as for those residents with substantial trauma backgrounds who heavily rely on body language and nonverbal cues to assess for safety), as well as provide professional insights into risk management, assessment, therapeutic programs and therapeutic climate. A further

[25] Andrews, DA, Bonta, J & Wormith, JS 2011, 'The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention?', *Criminal Justice and Behaviour*, vol. 38, no. 7, pp. 735-755. DOI: 10.1177/0093854811406356

identified limitation of current telehealth provision of psychological services is that residents can only access this via the iPad within the family room, which creates a tension between demands for use of the family room to interact with family members versus use for psychological services via telehealth. Additional infrastructure is required to support residents to engage with both formal (e.g., mental health professional) and informal (i.e., family) support networks, rather than AYDC staff needing to negotiate tensions between these presently competing demands which should instead be operating in tandem to support resident wellbeing and rehabilitation.

The tensions between benefits and limitations of onsite versus offsite psychological services were recognised by staff. Cited limitations regarding onsite psychological service provision included a risk of perceived alignment with AYDC staff rather than residents, which could lead to reduced engagement by residents. Multiple staff suggested a hybrid model of psychological service delivery to meet organisational and resident needs, with a psychologist onsite 2-3 days per week alongside provision of telehealth services. This proposed model certainly has merit and is one that should be considered for implementation, particularly as the remote service provision appears more readily staffed than a full-time psychologist onsite.

At present residents are able to access telehealth psychological services provided by a clinic based in Melbourne, Australia. There are a minimum of three hours of telehealth appointments available to be booked by residents each week, with additional appointments able to be organised on demand. This telehealth psychological service had only commenced in the weeks prior to the Inspectorate site visit at AYDC and as such limited information regarding its efficacy and acceptability by residents could be provided. Staff reported hope that telehealth services may afford a method of through-care psychological support for residents upon exiting AYDC, although it was not clear how these individuals would pay for private psychological services once they left AYDC. When queried about processes and policies regarding management of referrals should demand exceed availability of psychological services, staff indicated that to date this had not occurred however if it did in the future staff would triage access based on immediacy and nature of need. Given that a majority of offenders present with pre-existing (and often untreated) mental health issues, a formal documented process for ensuring ready access to required supports is required.

A child and adolescent psychiatrist attends onsite at AYDC once per month, in addition to telehealth consultations as required by staff and residents during the interim between onsite visits. The psychiatrist was clearly well respected and valued by AYDC staff, with a desire for more frequent onsite presence due to the positive impacts her skills have for residents and staff alike. Staff also reported that increased onsite presence by the psychiatrist would assist in managing perceived risks of potential malingering or intentional misrepresentation of symptoms by residents to gain access to medications or resources. The desire for additional psychiatric intervention is likely also related to the absence of a designated paediatrician, although it is acknowledged that in-reach services are provided by a paediatrician in Hobart and another in the North West, as well as other paediatricians as required.

It was evident in discussions with AYDC staff that despite the respect and regard they have for mental health professionals affiliated with the AYDC, they perceive the current mental health services as insufficient to meet resident needs. Given that staff are witness to the needs and experiences of residents, they are well placed to comment on the efficacy of existing approaches to support the mental health and wellbeing of residents. It was also evident that there is an expectation of increased psychological safety for staff and residents with increased access to mental health services.

Recommendation 8
Increased access to trained mental health professionals to support resident and staff wellbeing

Staff reported that a high proportion of residents present to AYDC with pre-existing substance (alcohol, licit and illicit substance) use issues. Substance use is a complex and multifaceted problem that can undermine rehabilitative efforts and increase risk of recidivism following release[26]. Further, substance use problems cause significant burden in the broader community, accounting for 1.8% of the total disease burden in

[26] Stoolmiller, M, Blechman, EA 2005, 'Substance use is a robust predictor of adolescent recidivism', *Criminal Justice and Behavior*, vol. 32, no. 3, pp. 302-328. DOI: 10.1177/0093854804274372

Tasmania in 2016[27]. Young people and those experiencing mental illness, as well as gender diverse individuals, are at greater risk of experiencing disproportionate harms associated with illicit substance use[28]. This is an important consideration given that research published by the Australian Institute for Health and Welfare reported that in 2019, 16% of young people aged 14-19 years had used an illicit substance in the 12 months previous to being surveyed[29]. For this reason, access to drug and alcohol specific counselling with trained mental health professionals is a vital resource for protecting the mental health and wellbeing of residents in both the short and long term and needs to be catered for within the AYDC mental health framework.

Transport Arrangements

Following sentencing, children and young people are temporarily housed in either the Launceston or Hobart Reception Prison until they can be transported to AYDC. It was reported that although policy mandates that children and young people be housed at Reception Prisons for a maximum of two-three hours, times often exceed that expectation. The primary reason for this delay was reported to be difficulties in arranging appropriate transport. It was reported that a private security company currently holds the tender for transport of children and young people between Reception Prisons and AYDC and that there are regularly delays of hours in notifying the private security company of the need for transportation, and resultant provision of this service. It has been reported that in some instances young people are arriving at AYDC at 2am or 3am due to the extensive delays in sourcing and providing transport from Reception Prisons. Delays in being relocated out of Reception Prisons negatively impacts the mental health and wellbeing of children and young people due to exposure to adult offenders, accommodations that were not designed to house children and young people, and prolonged anxiety and worry associated with the unknowns of custodial sentencing. As a result, children and young people in these circumstances are likely to experience increased emotional dysregulation and have reduced psychological resources to manage their behavioural responses to these challenges.

[27] Drug Education Network 2018, *Tasmanian alcohol, tobacco and other drug (ATOD) brief intervention framework,* Drug Education Network, Hobart, <https://interactive.den.org.au/toolbox/TasmanianATODBriefInterventionFramework_2018.pdf>

[28] Department of Health and Aged Care 2017, *National Drug Strategy 2017-2026,* Australian Government, Canberra, <https://www.health.gov.au/resources/publications/national-drug-strategy-2017-2026>

[29] Australian Institute of Health and Welfare 2020, 'National Drug Strategy Household Survey 2019', *Drug statistics series no. 32*, Cat. no. PHE 270, Australian Government, Canberra, viewed 5 April 2022 <https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/contents/summary>.

In turn, these negative experiences can influence interactions and experiences upon arrival at AYDC and detract resources from pre-existing mental health needs in an already limited mental health framework.

Further, it was reported that when being transported by the private security company children and young people are not afforded comfort breaks to hydrate, eat or use bathroom facilities. It was reported that this was due to perceived security risks for the security company's staff (noting that the private security company was not part of this review and therefore unable to provide a response or rationale to the reported transport conditions). When basic needs are not being met, it poses a threat to an individual's sense of psychological safety. When experiencing perceived threat, individuals experience negative affect and are more likely to respond with anger, hostility and impulsiveness. If AYDC residents arrive at court experiencing this affective profile there is an increased risk of negative interactions in the judicial process, potentially reinforcing stereotypes held by the young person that can shape engagement in rehabilitative efforts as has been demonstrated in other offender contexts[30].

Recommendation 9

Review policies and procedures employed by external contractors providing transport for Ashley Youth Detention Centre residents with a specific focus on protecting basic physiological needs (food, hydration, toileting) and psychological safety (supported by prioritised transport between Reception Prisons and Ashley Youth Detention Centre)

Evidence Based Practice

It is evident when reviewing previous custodial inspectorate reports, publicly available statements from the Commissioner for Children and Young People (Tasmania)[31], and interviews conducted as part of this evaluation that AYDC staff are working to engage a more therapeutic and rehabilitative context for residents. The implementation of a

[30] Moore, KE, Stuewig, JB & Tangney, JP 2016, 'The effect of stigma on criminal offenders functioning: A longitudinal mediational model', *Deviant Behavior*, vol. 37, no. 2, pp. 196-218. DOI: 10.1080/01639625.2014.1004035

[31] Commissioner for Children and Young People Tasmania 2021, *Ashley Youth Detention Centre*, media release, Commissioner for Children and Young People Tasmania, September, <https://www.childcomm.tas.gov.au/wp-content/uploads/CCYP-Media-AYDC-091021.pdf >.

revised Behavioural Support Program (the Behavioural Development Program; BDP) that addressed the punitive component evident in earlier iterations is evidence of this increased focus on therapeutic rehabilitation. The BDP is based on a trauma informed Practice Principles and Learning Development Framework which also incorporates cognitive-behavioural principles and in this way reflects evidence-based practice regarding behaviour change.

Commendation 3
AYDC staff are engaging in practices designed to provide a more therapeutic and rehabilitative context for residents

However, AYDC staff reported that evidence-based practices are not always engaged or underpin decision making or program development. Further, it was reported that some staff interpret BDP differently, resulting in inconsistencies in its implementation and adherence. These inconsistencies can undermine resident adherence and progress as consistency in expectations and consequences underpins effective behavioural change strategies[32].

The reported inconsistency in implementation/adherence to the revised BDP may be due in part to the absence of formalised professional supervision frameworks that underpin and support the implementation of evidence-based practices. It was also suggested by those interviewed in the context of this evaluation that current staff resourcing limits the capacity of staff to invest time and resources to engage with existing literature or research to inform a fit-for-purpose evidence-based practice approach. Despite these constraints, it was detailed AYDC staff developed the current BDP in 2020 by reviewing existing literature and making adaptations based on the needs of AYDC[33]. The current BDP was reportedly implemented in September 2021. There have been no formal evaluations or reviews of the BDP to date (see recommendation regarding governance).

[32] Van Kampen, HS 2019, 'The principle of consistency and the cause and function of behaviour', *Behavioural Processes*, vol. 159, pp. 42-54. DOI: 10.1016/j.beproc.2018.12.013
[33] The nature of this research and adaptations were not able to be expanded upon by those who provided information about the BDP.

Current practice for mental health intervention involves a stepped-care model that varies in intensity and delivery format dependent on client needs[34]. Although it is recognised that a majority of AYDC residents will require more intensive intervention needs than other young people in the community and that their mental health needs may have precipitated or maintained their offending behaviours, their readiness for change (Figure 1) may influence their capacity to engage with treatment.

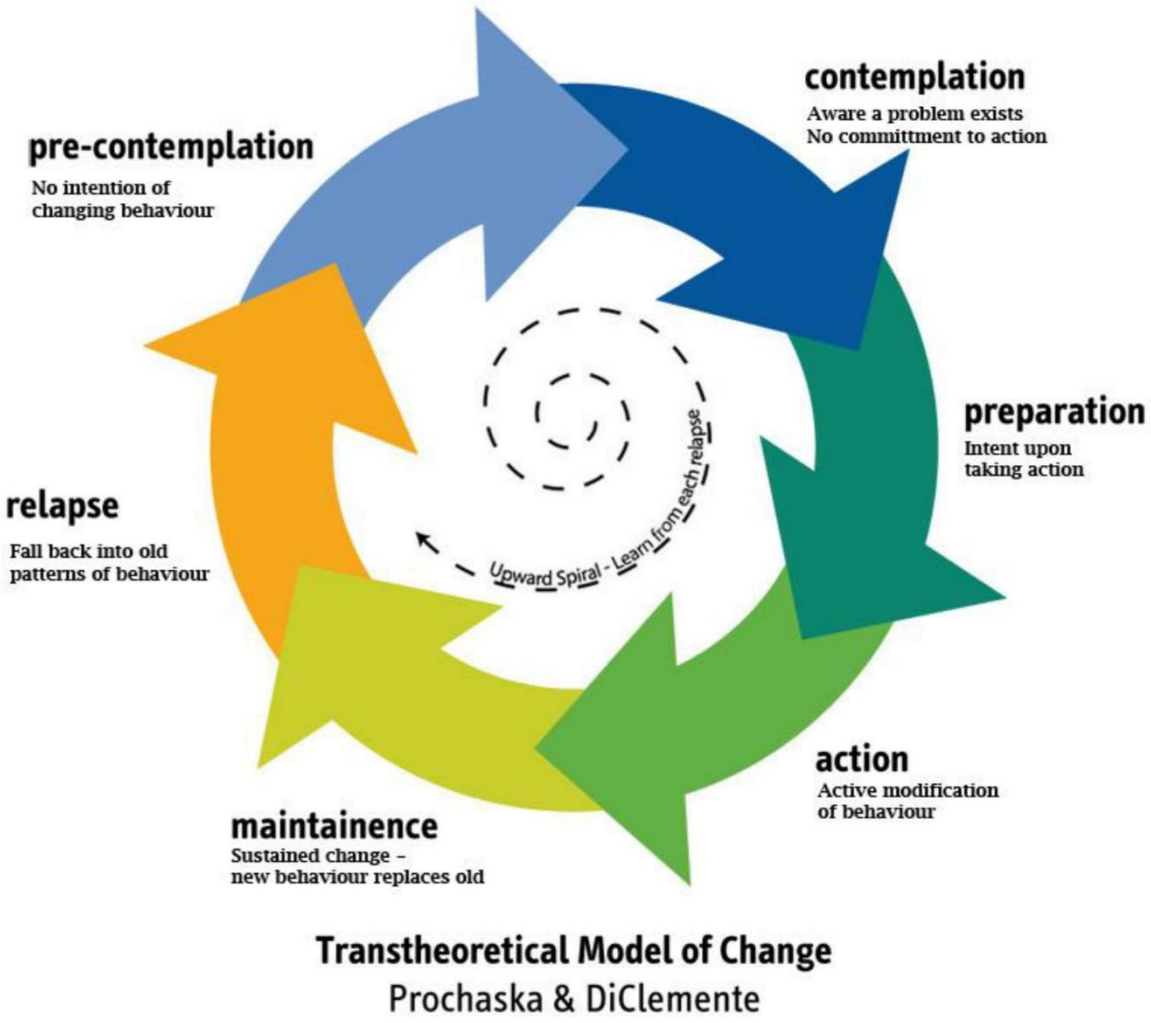

Figure 1. Transtheoretical Model of Change as proposed by Prochaska and DiClemente [35]

[34] Berger, M, Fernando, S, Churchill, AM, Cornish, P, Henderson, J, Shah, J, Tee, K & Salmon A 2021, 'Scoping review of stepped care interventions for mental health and substance use service delivery to youth and young adults;, *Early Intervention in Psychiatry*, vol. 16, no. 4, pp. 327-341. DOI: 10.1111/eip.13180

[35] Shtull, S n.d., *The five stages of change,* The Relationship Blog, Seattle, <https://www.therelationshipblog.net/wp-content/uploads/2016/06/change_l.jpg>.

In such instances, stepped care models may be beneficial in that they offer a range of entry points (online self-directed; online therapist assisted; therapist facilitated, etc.; see Figure 2) for such individuals to better align with their readiness to change. In doing so, progression through stages of change can be facilitated to a point where the resident can engage in treatment intensity matched to their needs. It is however recognised that there remains a paucity of robust research investigating the efficacy of stepped-care approaches specifically as they relate to mental health outcomes for children and adolescents[36].

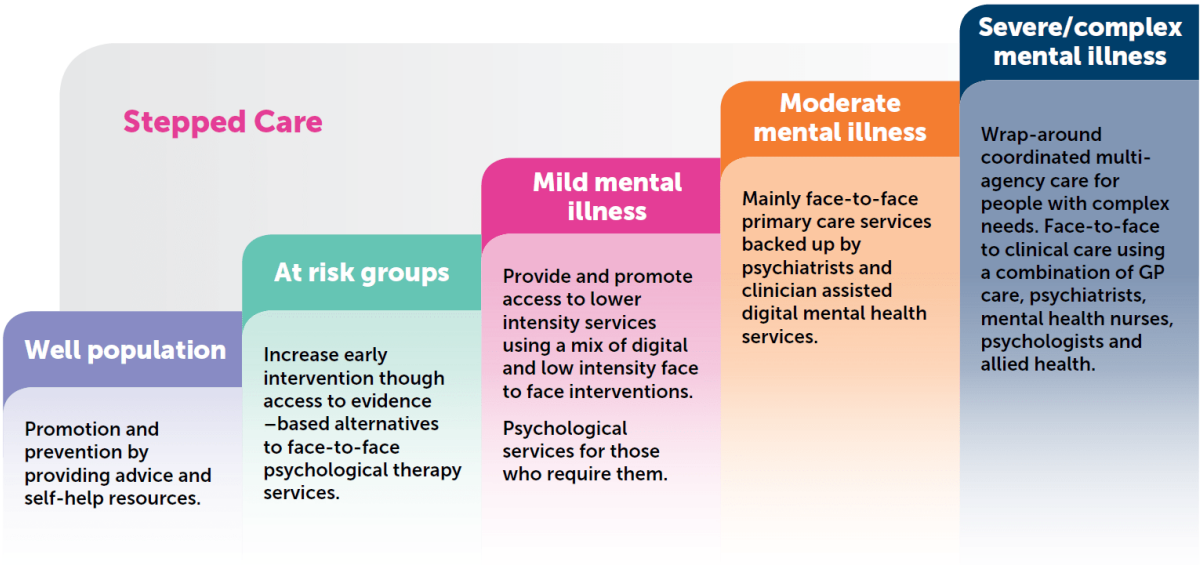

Figure 2. Stepped Care Approach to Mental Health Intervention [37]

Recommendation 10

Implement a formal professional development framework in AYDC to support implementation and consolidation of evidence-based, contemporary practices relating to therapeutic climate and therapeutic jurisprudence

[36] Berger, M, Fernando, S, Churchill, AM, Cornish, P, Henderson, J, Shah, J, Tee, K & Salmon A 2021, 'Scoping review of stepped care interventions for mental health and substance use service delivery to youth and young adults;, *Early Intervention in Psychiatry*, vol. 16, no. 4, pp. 327-341. DOI: 10.1111/eip.13180

[37] Murray PHN n.d., *A stepped care approach to mental health,* Australian Government, Canberra, <https://i0.wp.com/www.murrayphn.org.au/wp-content/uploads/2018/11/Stepped-Carediagram.png?ssl=1>

AYDC staff advised that staff training needs including, but not limited to, mental health were not being met due to staff resourcing shortages. Thus, despite budget allocation to employ subject matter experts to deliver such training it has not progressed as staff are unable to be released from existing activities to attend. In addition to the content areas regarding trauma-informed practice as identified as desirable by AYDC staff[38], it is also recommended that training in neurodivergence and neuro-affirmative practice be engaged given the diversity of resident needs. Further training on disability awareness (including, but not limited to, cognitive disability) would also be of benefit in increasing staff self-efficacy as well as service provision to residents. Staff key performance indicators should also be mapped to competency development associated with these training opportunities.

Recommendation 11
Ashley Youth Detention Centre staff be provided training in neurodivergence and neuro-affirmative practice

A number of staff expressed concern regarding the expectations regarding provision of trauma therapy to residents staying at AYDC. The prevailing staff opinion is that while trauma-informed approaches are vital to working with residents, trauma therapy is beyond the scope of their skills sets and there were concerns about the possible risks of commencing trauma therapy with young people who may not complete this intervention prior to exiting AYDC. The research evidence aligns with the staff perspectives. Whilst trauma-informed practice needs to underpin all interactions with residents given the correlation between trauma and offending behaviours[39], it is important to note that it will not always be appropriate to engage a resident in trauma therapy during their sentence. Trauma therapy requires stability in the therapeutic relationship which may not be readily facilitated either within (due to difficulties recruiting to mental health positions within the organisation) or following release (due

[38] A majority of staff noted that they have had the opportunity to engage in professional development regarding trauma-informed practice. However, they acknowledged that they would benefit from ongoing training in this regard. This is evidence of their commitment to ensuring contemporary practice is engaged to support the mental health needs of AYDC residents.
[39] Vitopoulos, NA, Peterson-Badali, M, Brown, S & Skilling, TA 2019, 'The relationship between trauma, recidivism risk, and reoffending in male and female juvenile offenders', *Journal of Child & Adolescent Trauma*, vol. 12, no. 3, pp. 351 364. DOI: 10.1007/s40653-018-0238-4

to disengagement or difficulty with access) from AYDC. Even with stability in this relationship, trauma therapy is generally considered a medium-to-long term intervention framework that is not ideally suited for short-term intervention frameworks which may not be readily accommodated within the custodial sentence. There is also some evidence that under certain circumstances trauma therapy may result in increased distress[40]. For this reason, trauma-informed approaches to mental health are vital in the AYDC context, however trauma therapy may not be appropriate for all residents. Determining a young person's readiness for, and capacity to benefit from, trauma therapy can only be determined by a trained mental health professional on a case-by-case basis.

The recommended professional development framework as detailed on page 91 of this report also needs to include access to professional supervision for all staff. Professional supervision is an overarching term that may include clinical supervision, discipline specific supervision, peer supervision, and mentorship (Table 1). The overarching purpose of professional supervision is to provide a quality assurance framework for professional practice, as well as an opportunity for professionals to proactively and retrospectively reflect on challenging work-related experiences in a psychologically safe environment designed to validate, problem-solve and support best practice.

[40] Pitman, RK, Altman, B, Greenwald, E, Longpre, RE, Macklin, ML, Poiré & Steketee, GS 1991, 'Psychiatric complications during flooding therapy for post-traumatic stress disorder', *Journal of Clinical Psychiatry*, vol. 52, no. 1, pp. 17-20.

Table 1. Professional Supervision Components

	Clinical Supervision	**Discipline Specific Supervision**	**Peer Supervision**	**Mentorship**
Supervision focus	Clinical care provision Professional development Reflective practice	Service provision Professional development Reflective practice	Service provision Professional development Collegial support	Career planning Professional development
Supervision provider	Senior professional within the same discipline working with the same population	Senior professional within the same discipline	Peers with whom an individual works Supervision may occur with people who are at the same of different levels of appointment and experience	Line manager Senior professional within the same profession/discipline

It is noted that health staff within AYDC are provided access to professional supervision as it is a requirement of their professional registration. However, at the time of this report this framework had not been extended to all AYDC staff. As with other components of the required mental health practice framework, this professional supervision needs to be work-loaded to ensure that it is able to be engaged in and benefited from (noting the benefits to staff and residents). Access to high quality professional supervision has been demonstrated to enhance the effectiveness of provided care and in doing so improve the mental health outcomes of people for whom they are providing care[41]. The benefits of professional supervision are best achieved when the supervision is delivered by experienced professionals, which further reinforces the need to recruit and retain experienced staff to the AYDC staffing profile.

A further consideration as it relates to evidence-based practice is the documented relationship between mental health and exposure to nature/natural environments[42], specifically the benefits that exposure to nature has on mental health. At present there are some outdoor basketball systems provided for AYDC residents; however, beyond this there is no access to seating or provision of shade structures that would encourage residents to spend time outside. Where appropriate, educational classes may also be conducted outside. Opportunities to engage in outdoor activities as a reward for positive behaviour currently exist, although opportunities to expand these programs should also be explored.

In addition to the documented links between nature exposure and mental health, increased time spent outside will increase sun exposure that can support Vitamin D production. Vitamin D deficiencies are well documented in Tasmanian adolescent and adult populations[43]. In addition to the risks to bone density and multiple sclerosis,

[41] Snowdon, DA, Leggat, SG, & Taylor, NF 2017, 'Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review', *BMC Health Services Research*, vol. 17, no. 1, pp. 786-796. DOI: 10.1186/s12913-017-2739-5

[42] Twohig-Bennett, C & Jones, A 2018, 'The health benefits of the great outdoors: A systematic review and meta-analysis of greenspace exposure and health outcomes', *Environmental Research*, vol. 166, pp. 628-637. DOI: 10.1016/j.envres.2018.06.030

[43] van der Mei, IAF, Dore, D, Winzenberg, T, Blizzard, L & Jones, G 2012, 'Vitamin D deficiency in Tasmania: a whole of life perspective', *Internal Medicine Journal*, vol. 42, no.10, pp. 1137-44. DOI: 10.1111/j.1445-5994.2012.02788.x

vitamin D deficiencies have been linked to increased risk of negative mental health including depressive symptoms, sleep disturbances, and cognitive decline[44].

Recommendation 12

Installation of shade cloths or other structures to encourage Ashley Youth Detention Centre residents to spend time outside in nature

Governance

AYDC staff reported that existing Memoranda of Understanding (MOUs) have not been consistently adhered to by external service providers, and that at times the services provided have been insufficient to their needs. These shortfalls result in increased pressure on AYDC staff who report insufficient training and expertise to provide the needed care. As a result, resident needs are going unmet and this can increase the risk of further deterioration in mental health and increase risk of future reoffending behaviours, given the documented link between mental ill-health and offending behaviours[45].

These MOUs are also vital to provide through-care for mental health needs once residents are released into the community. In addition to the services of psychologists and psychiatrists, the services identified as vital to providing mental health care needs of AYDC residents include (but may not be limited to):

- Sexual Assault Support Service (SASS),
- headspace,
- the Link,
- Head to Health,
- Strong Families Safe Kids,
- Youth Justice

[44] Huiberts, LM & Smolders, KCHJ 2021, 'Effects of vitamin D on mood and sleep in the healthy population: Interpretations from the serotonergic pathway', *Sleep Medicine Reviews*, vol. 55, 101379. DOI: 10.1016/j.smrv.2020.101379

[45] Brennan, PA, Mednick, SA & Hodgins, S 2000, 'Major mental disorders and criminal violence in a Danish birth cohort', *Archives of General Psychiatry*, vol. 57, no. 5, pp. 494 500. DOI: 10.1001/archpsyc.57.5.494

Additionally, the vital role of speech pathologists, occupational therapists, nutritionists [46] and other professionals (e.g., cultural elders, personal trainers) in identifying and responding to the needs of AYDC residents was further highlighted. At the time of assessment, access to these professionals was limited despite a widely acknowledged role for them in addressing the needs of AYDC residents. Addressing foundational physical and mental health needs of AYDC residents provides a foundation on which higher order psychological needs can be addressed (Figure 3)[47], in turn reducing risks of recidivism following release into the community.

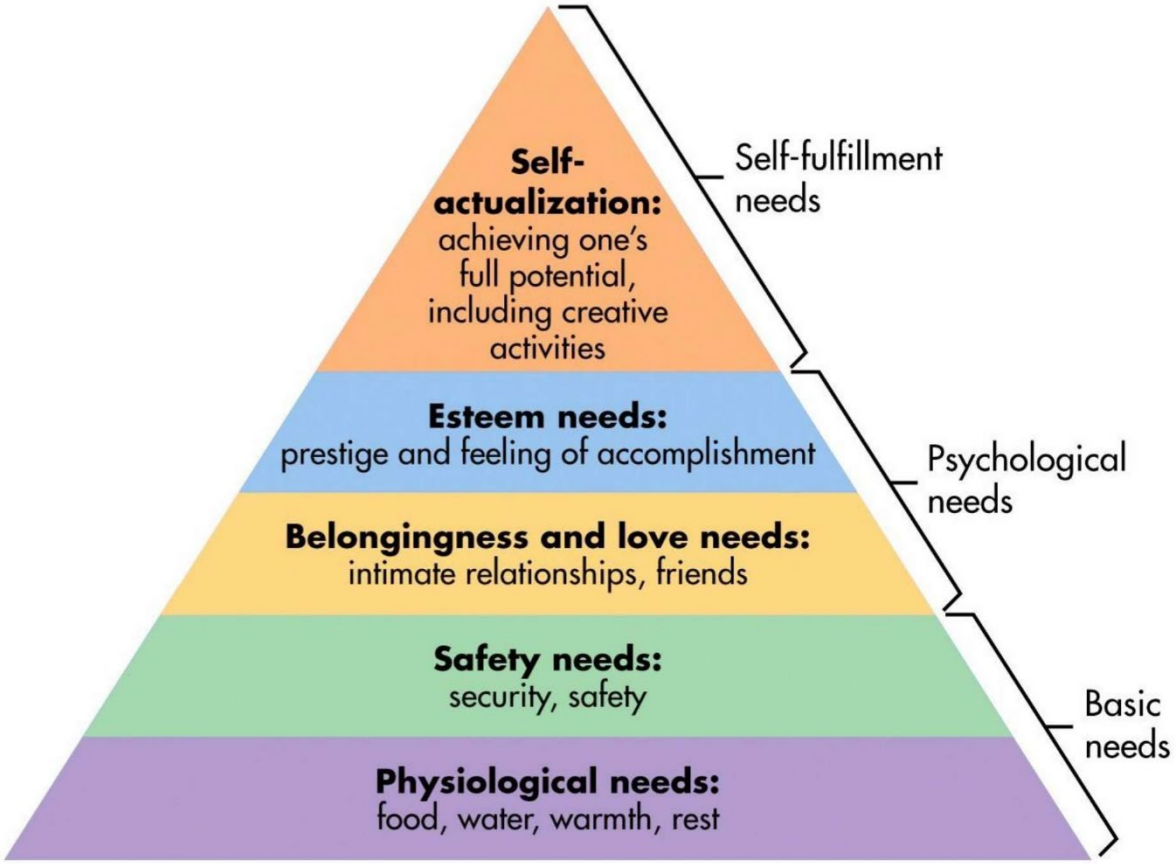

Figure 3. Hierarchy of Needs Underpinning Psychological Safety Facilitating Achievement of Higher Order Psychological/Mental Health Needs

[46] It was noted by multiple staff that many children and young people enter AYDC in a state of malnutrition. Malnutrition impacts brain development and function, limiting capacity for optimal mental health (e.g., Chertoff, M 2015, 'Protein malnutrition and brain development', *Brain Disorders and Therapy*, vol. 4, no. 3, 168.)
[47] Maslow, AH 1954, *Motivation and Personality,* Harper & Row, New York City.

Recommendation 13

Review the range and implementation processes of Memorandum of Understanding (MOU) with external service providers to ensure access to appropriate and timely mental health care

At present there are no formal planned reviews of existing processes relating to mental health and behavioural intervention programs. There are documented processes regarding reviews and evaluations[48], however no formalised governance structures in this regard to ensure their occurrence. Evaluation of programs, incentives and other interventions are required to ensure they are meeting objectives and supporting positive behavioural change for residents and enhancing staff professional skills. It was reported by staff that there is a planned annual review of the BDP, including reinforcements (rewards) employed to support positive behaviour, however there were no firm timelines for this review. The major inhibiting factor is around staff resourcing. There was clear awareness of the need to develop these frameworks and evaluation processes, however insufficient resourcing to do so. This is a further example of the importance of ensuring adequate staffing of the facility, as until this is remedied many of the recommendations contained within this report cannot be actioned.

It is also recommended that a representative from health be present at multidisciplinary team (MDT) meetings to ensure that health is a core consideration in all decisions and there is increased consistency in experiences for residents as all departments are regularly communicating regarding their needs. It is acknowledged that health staff previously attended these meetings although discontinued this action due to perceived limited scope for input and advice. Developing a clear governance structure that details

[48] E.g. Department of Communities 2020, *AYDC Practice Framework Poster*, Tasmanian Government, Hobart, <www.communities.tas.gov.au/__data/assets/pdf_file/0035/174599/AYDC-Practice-Framework-Poster-FINAL-202012.pdf>;
Department of Communities 2020, *AYDC Practice Framework*, Tasmanian Government, Hobart, <www.communities.tas.gov.au/__data/assets/pdf_file/0034/174598/AYDC-Practice-Framework-FINAL-202012.pdf>;
Department of Communities 2021, *Reforming Tasmania's Youth Justice System,* Tasmanian Government, Hobart, <www.communities.tas.gov.au/__data/assets/pdf_file/0031/196447/Reforming-Tasmanias-Youth-Justice-System-Final-Web-1-Dec_wcag.pdf>.

the scope, purpose, and professional contributions will ensure the best use of multidisciplinary knowledge base to maximise resident outcomes.

Recommendation 14

A representative from health be present at AYDC multidisciplinary team (MDT) meetings to ensure that health is a core consideration in all decisions

This governance structure also needs to include resident representation processes to ensure that lived experience is integrated into decision making. It is evident that residents have valuable insights to share with AYDC staff, for example, it was reported that residents had emphasised a desire to move away from food-based incentives within the BDP to other incentives including additional gaming time, gym time, and outdoor activities. The effectiveness of behavioural support programs is contingent on the reinforcements being relevant, achievable, and valuable. As such, the success of the BDP is contingent on resident input regarding the process, particularly reinforcers being used as a motivator for positive behaviour. It is acknowledged that ad-hoc opportunities exist for residents to provide feedback regarding their needs and experiences, however a formalised process enshrines and protects the value of these resident contributions.

Further, there were reported inconsistencies in the nature and effectiveness of communication between different areas of work within AYDC, as well as with external stakeholders and service providers. Although this situation may again be in part due to staffing shortages, it is important to recognise that inconsistent or communication failures can undermine the consistency of resident experiences, as well as undermine staff cohesion and associated psychological safety.

Recommendation 15

Review of governance structure and planned reviews of action plans, policies and communication processes

It is acknowledged that the need for a clear, understood, shared and trauma-informed governance structure was recommended within the Noetic report[49] however this has yet to be implemented. Again, this may be due to the intention to implement a new governance structure as part of the new model of youth detention in Tasmania. However, as previously indicated in the current report, there are continued delays in the release of this framework as well as appropriate change management processes. The existing governance structures must be addressed even if this precedes implementation of the new model of care for children and young people subject to custodial sentences in Tasmania.

[49] Department of Communities 2016, *Custodial Youth Justice Options Paper,* Tasmanian Government, Hobart, <www.communities.tas.gov.au/__data/assets/pdf_file/0025/36394/99010_Custodial_Youth_Justice_Opt ions_Paper_October_2016_-_Report_for_the_Tasmanian_Government.pdf>

Reception Prisons

There are currently two Reception Prisons in Tasmania - Hobart and Launceston. The facilities provide accommodation for individuals charged under Tasmanian and/or Commonwealth legislation pending legal proceedings; and also detain convicted offenders, pending their classification and placement at other correctional facilities in Tasmania.

At the time the current evaluation was undertaken the Southern Remand Centre (SRC) had not yet been opened, and beyond a limited tour of the facilities within the SRC no specific information was provided regarding the SRC. As such, evaluation of the SRC is beyond the scope of the current evaluation and associated report.

Within this section of the report, information - including that pertaining to commendations and recommendations - pertain to both the Hobart and Launceston Reception Prisons, unless otherwise stated.

Launceston Reception Prison

The Launceston Reception Prison (LRP), formerly the Launceston Remand Centre, is a prison primarily for individuals newly remanded to custody in Launceston, Tasmania. Its main use is for watch house accommodation, short stay accommodation on reception for induction purposes and to facilitate in person court appearances. It is located in the main police building in Launceston.. At the time of inspection, there were a number of inmates serving medium to long-term sentences permanently residing at the LRP due to safety and related concerns, or negative impacts of geographic dislocation from family, if they were to be housed within the Risdon Prison Complex. The LRP is scheduled for a range of renovations and upgrades to its resources and services to better accommodate inmate and staff needs, including increased security screening. These renovations had yet to commence at the time of inspection.

Hobart Reception Prison

The Hobart Reception Prison (HRP), formerly the Hobart Remand Centre, is a prison primarily for individuals newly remanded to custody in Hobart, Tasmania. Its main use is for watch house accommodation, short stay accommodation on reception for induction purposes and to facilitate in person court appearances. Opened in January 1999, the centre was built over five floors and accommodates 36 single-occupancy cells for persons awaiting trial, plus 10 watch house cells. At the time of inspection,

there were a number of inmates serving medium to long-term sentences permanently residing at the Hobart Reception Prison due to safety and related concerns if they were to be housed within the Risdon Prison Complex.

Overarchingly, through inspection of the Reception Prison facilities and interactions with correctional and health staff it is evident that there are insufficient infrastructure and staffing resources to adequately support the mental health needs of prisoners located in these venues, particularly those presenting with chronic, high intensity or acute intervention needs.

Physical Environment

It is recognised that staff are aware of the limitations of the existing physical environment on their ability to provide for the mental health needs of residents, and constraints imposed by the existing physical location and structure in meeting these needs. Irrespective of these limitations, it is important to identify key issues that relate to the mental health and wellbeing of staff and residents located in Reception Prisons in Tasmania.

In both Reception Prisons staff noted that the environment is not adequate to support the needs of longer-term residents, however, are currently used for this purpose. There was considerable hope that the opening of the SRC would decrease the reliance on Reception Prisons to house longer-term residents, although staff acknowledged that ongoing concerns for safety of given prisoners may mean longer term residents remain. Correctional staff on both sites identified a need for individuals who are residing in Reception Prisons for longer terms to have access to meaningful activities and opportunities for self-development. Correctional staff believed that there were discussions occurring to introduce access to online training courses for prisoners, however, were not aware of specific details or timeframes regarding these opportunities. The importance of meaningful activities and opportunities for self-development in promoting and sustaining positive mental health are discussed in further detail later in this report.

There is minimal access to natural light and external fresh air (including within the exercise yard in the LRP). The importance of exposure to natural light (i.e., optical radiation) on mental health and wellbeing has recently been summarised in a review

published by Bertani et al. [50]. In addition to helping to regulate circadian rhythms (which influence the sleep-wake cycle, which influences mood and cognitive function), natural light exposure can also assist in managing seasonal affective disorder symptoms[51]. In contrast, chronic exposure to artificial light such as that found in LRP has been associated with neurotransmitter dysregulation associated with depressive symptoms in some populations. Further, limited exposure to natural light can limit Vitamin D production. As detailed earlier in this report when considering AYDC residents, Vitamin D deficiencies are well documented in Tasmanian adolescent and adult populations[52]. In addition to the risks to bone density and multiple sclerosis, vitamin D deficiencies have been linked to increased risk of negative mental health including depressive symptoms, sleep disturbances, and cognitive decline[53]. The above detailed impacts are most relevant to the residents of LRP, but also impact staff who work long and repeated shifts in this environment and those within HRP with limited access to the enclosed outdoor exercise yard.

Given the limited access to natural light sources, it is important to ensure that lighting of cells is appropriate. It was observed within LRP that there was a lack of consistency in the approach to lighting, with an extreme example being a pink-based light in cell 11 (a stepdown cell). Combined with a prominent bulkhead, cell 11 creates a perception of being a smaller room and may cause anxiety for individuals with claustrophobia. It may also lead to perceptual disturbances that may be experienced as distressing for some residents. Similarly, lighting in the videoconferencing level of HRP was this same, pink-based lighting. Although only two examples, these have been highlighted to demonstrate the opportunity to address the current lighting patterns which is relatively easy to address and readily achieves improvements in the physical environment.

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[50] Bertani, DE; De Novellis, AMP, Farina, R; Latella, E, Meloni, M, Scala, C, Valeo, L, Galeazzi, GM & Ferrari, S 2021, '"Shedding light on light". A review of the effects on mental health of exposure to optical radiation', *International Journal of Environmental. Research and Public Health*, vol. 18, no. 4, 1670. DOI: 10.3390/ijerph18041670

[51] Bertani, DE; De Novellis, AMP, Farina, R; Latella, E, Meloni, M, Scala, C, Valeo, L, Galeazzi, GM & Ferrari, S 2021, '"Shedding light on light". A review of the effects on mental health of exposure to optical radiation', *International Journal of Environmental. Research and Public Health*, vol. 18, no. 4, 1670. DOI: 10.3390/ijerph18041670

[52] van der Mei, IAF, Dore, D, Winzenberg, T, Blizzard, L & Jones, G 2012, 'Vitamin D deficiency in Tasmania: a whole of life perspective', *Internal Medicine Journal*, vol. 42, no.10, pp. 1137-44. DOI: 10.1111/j.1445-5994.2012.02788.x

[53] Huiberts, LM & Smolders, KCHJ 2021, 'Effects of vitamin D on mood and sleep in the healthy population: Interpretations from the serotonergic pathway', *Sleep Medicine Reviews*, vol. 55, 101379. DOI: 10.1016/j.smrv.2020.101379

Of the research that has specifically investigated the impacts of various artificial light exposures on mental health, it is well documented that exposure to artificial blue light increases alertness, and white light best replicates exposure to natural light[54]. Although recent research has indicated that in an isolated and confined environment (simulated space habitat), random changes to artificial light colour may have assisted in managing feelings of monotony within a seven-day period[55], this data has not been replicated nor is this a feasible strategy in the Reception Prisons given the need to prioritise other work activities.

Recommendation 16

Increased access to natural light and consideration of mental health needs in renovations and redevelopments of Reception Prison facilities

The observation room(s) within the LRP are located alongside standard holding cells. LRP staff identified that individuals under observation for mental health or other health reasons may be disturbed during standard watch-house checks due to their location. Strategies that have been implemented by staff to mitigate these disturbances include use of lower lighting (lighting is required for closed-circuit TV (CCTV) requirements), correctional officers turning off their lights when conducting checks if there are no other prisoners in the immediate vicinity, and correctional officers altering their walk patterns to avoid disturbing prisoners in observation rooms (as prisoners in these rooms can be observed through CCTV). These accommodations are evidence of both an awareness of the needs of prisoners presenting with mental health needs, as well as efforts to accommodate these needs within infrastructure constraints.

Social connectedness, and relatedly social support, has been strongly correlated with improved mental health outcomes across diverse populations[56]. Although most research investigating social support and mental health in prisoner populations has

[54] Bertani, DE; De Novellis, AMP, Farina, R; Latella, E, Meloni, M, Scala, C, Valeo, L, Galeazzi, GM & Ferrari, S 2021, '"Shedding light on light". A review of the effects on mental health of exposure to optical radiation', *International Journal of Environmental. Research and Public Health*, vol. 18, no. 4, 1670. DOI: 10.3390/ijerph18041670

[55] Jiang, A, Schlacht, IL, Yao, X, Foing, B, Fang, Z, Westland, S, Hemingray, C & Yao, W 2022, 'Space habitat astronautics: Multicolour lighting psychology in a 7-day simulated habitat', *Space: Science & Technology*, vol. 2020, article ID: 9782706. DOI: 10.34133/2022/9782706

[56] Fasihi Harandi, T, Mohammad Taghinasab, M, & Dehghan Nayeri, T 2017, 'The correlation of social support with mental health: A meta-analysis', *Electronic Physician*, vol. 9, no. 9, pp. 5212-5222. DOI: 10.19082/5212

focused on recently released inmates, there is evidence that for currently serving prisoners social support can reduce suicidal ideation and severity of mental health symptoms[57]. In the context of incarceration, social connectedness provides a sense of hope and can be a powerful motivator for positive behaviour change. Within the LRP there are two non-contact ("box") visiting resources (small, enclosed rooms in which prisoners and visitors are separated by a screen), as well as a single contact visit room. The contact visit room also served as a video-conferencing room. At the time of the evaluation the contact visit room was not available for use due to COVID-19 protocols. Correctional staff reported relatively low levels of use of non-contact visiting resources, although largely attributed the lower visiting levels to COVID-19 protocols and associated impacts. A review of staffing to facilitate full use of both contact and non-contact visiting rooms would assist in supporting social connectedness and social support for prisoners.

Within the "step-down" cells (i.e., those cells that are used to transition prisoners from observation to standard Reception Prison residence) standard bedding is provided to prisoners, although dependent on the prisoner presentation they may be provided Suicide and Self-Harm (SASH) bedding and gown. Staff advised that the decision regarding standard versus SASH accommodations is based on staff assessment, often undertaken as a collaborative decision between correctional and health staff. Staff also advised that on occasion prisoners have requested SASH accommodations, and when requested they are always provided for. It is recommended that decisions regarding SASH accommodations continue to be made collaboratively involving correctional staff, health staff, and prisoners (where appropriate). SASH gowns were observed to be a garment resistant to tearing or improvisation of self-harm activities and therefore fit for purpose. There were a variety of sizes available for use with prisoners of different physical statures.

Commendation 4
Decisions regarding SASH accommodations are made collaboratively between correctional staff, health staff, and prisoners (where appropriate)

[57] Richie, FJ, Bonner, J, Wittenborn, A, Weinstock, LM, Zlotnick, C & Johnson, JE 2021, 'Social support and suicidal ideation among prisoners with major depressive disorder', *Archives of Suicide Research*, vol. 25, no. 1, pp. 107-114. DOI: 10.1080/13811118.2019.1649773

Mental Health Resourcing

Correctional staff advised that although they are trained in basic medical first aid they are not provided specific mental health first aid training. However, due to the nature of their work and the needs of prisoners located within Reception Prisons, responding to mental health needs is a skill that needs to be rapidly learned by correctional officers. Mental Health First Aid (MHFA) training provides people with the skills to assist others presenting with mental health problems - whether the mental health problem is emerging, an existing mental health problem is being exacerbated by given circumstances, or someone is presenting in a mental health crisis[58].

Like physical first aid, mental health first aid is given until the person receives professional help or until the crisis resolves. Correctional staff demonstrated an openness to engaging in such training and recognised the benefit to their ability to support the needs of both prisoners as well as colleagues. Multiple correctional staff positively commented on the accessibility of nursing/health staff onsite to assist with addressing prisoner mental health needs as well as providing a resource for staff to debrief following challenging work-related events. Although there are a range of MHFA trainers available in Tasmania who could provide formalised MHFA training to correctional staff, health staff within custodial contexts are also well placed to develop and deliver purpose designed MHFA content to their colleagues. In addition to providing valuable and necessary professional development for correctional staff, development of a MHFA suite for custodial contexts is also an opportunity for the Tasmanian Prison Service to implement a nation-leading resource. Development of fit-for-purpose mental health resources and associated research evaluating such endeavours also creates a culture and reputation for innovative, context-specific mental health activities that can also serve as a recruitment incentive (further discussion of the role of innovation and research in custodial contexts is provided later in this report). It is however recognised that at this time health staff are under resourced and are unlikely to have capacity to both develop and deliver this content until staffing is increased. Despite these limitations it was identified that the Therapeutic Services Unit (TSU) were planning to develop a range of new training packages for correctional

[58] Australian Red Cross n.d., *MHFA - Mental Health First Aid*, Australian Red Cross, Melbourne, viewed August 2022, <https://firstaid.redcross.org.au/mental-health-first-aid/>.

staff regarding the needs of neurodivergent prisoners and deliver a revised SASH training process.

Both correctional and health staff reported concerns with the structural and staffing resources available to support prisoners presenting with mental health conditions. There was a pervasive belief from correctional staff that Risdon Prison is better equipped to support the needs of prisoners presenting with mental health concerns, particularly those requiring more intervention for chronic, high intensity, or acute presentations (including SASH) that necessitate resources commensurate with inpatient admissions. Correctional staff reported that they feel ill-equipped to appropriately support the mental health needs of prisoners and perceive that there are inequitable training opportunities for those in Reception Prisons compared to Risdon Prison.

Correctional staff within Reception Prisons detailed limited access to formal mental health training to support prisoner needs, and that when mental health needs are identified they liaise with health staff for support. Whilst this interdisciplinary collaboration promotes enhanced outcomes for prisoners and staff, it first relies on recognition by correctional staff that a prisoner is presenting with a mental health need. Additionally, the ability of correctional staff to proactively respond to mental health needs is emphasised by not having onsite access to health staff 24 hours. Given that correctional officers detailed high rates of prisoner processing outside hours, this poses a substantial risk to both prisoners and staff. Having said this, correctional staff are trained to identify key risk factors for mental health distress including first time in custody, serious crime, and family problems.

Recommendation 17
Mental Health training opportunities be provided to correctional staff in Reception Prisons

When queried regarding processing procedures for prisoners who present with lower levels of cognitive functioning or acquired brain injury, correctional staff detailed that their standard procedure is to seek advice from the onsite Health team for guidance on how to support the prisoner through this process whilst ensuring core intake/other

tasks are completed. More senior correctional staff detailed that through experience with such offenders they have learned to slow down the process of questioning to better aid prisoner understanding. Prisoners presenting with low functional literacy are supported to complete written forms by correctional staff and the prisoner will be relocated to a more private area away from other prisoners to protect their privacy and confidentiality. Interpreters are available by phone to assist prisoners with low English literacy skills and can also travel to court proceedings as required. Disclosures or assessments indicating that a prisoner is at risk of suicide or self-harm are immediately linked in with the Health team. All correctional officers within Reception Prisons who participated in the interview process of this evaluation were able to recount the process of processing a new prisoner and accommodations available to support their diverse mental health needs. Having said this there was limited awareness of neurodivergent practice.

From an infrastructure perspective, correctional staff detailed that they do not have sufficient rooms to accommodate the increasing mental health presentations of prisoners within Reception Prisons. This has resulted in occasions where prisoners under mental health observation are housed in standard watch house cells which are not designed for this purpose. Correctional staff detailed the risks this posed to prisoners, but also correctional staff who experience greater cognitive and psychological burden for the health and safety of prisoners in these situations. Health staff also reported concerns about access to appropriate mental health care in emergencies, particularly outside rostered health shifts explaining that there could be delays in external agencies providing support. Although staff acknowledged that these delays likely resulted in part from the reported under resourcing of the Tasmanian Health Service, there was also a concern that external agencies were reluctant to engage with prisoners for the purpose of healthcare provision. Although it was detailed that the SRC would better provide for the mental health needs of prisoners compared to the existing Reception Prisons, it was not clear what process would exist to facilitate transport of prisoners to this venue and such transport may not always be feasible from either Reception Prison - particularly Launceston - without extensive planning.

Correctional staff reported that there were repeated experiences where decisions made regarding prisoner mental health needs and staff safety were perceived to be undermined by those in more senior positions, particularly when recommendations were made to relocate prisoners to Risdon Prison due to SASH risk. When these decisions were disregarded or reversed staff reported feeling physically and psychologically unsafe, particularly in instances where prisoners focused dissatisfaction towards a particular correctional officer. Information provided suggested that these situations were more likely to occur for LRP staff and prisoners, which may be due in part to geographic dislocation from Risdon Prison creating additional barriers to ready transfer of prisoners requiring higher levels of support.

Recommendation 18
Appropriate resourcing and governance structures to support transfer of offenders with higher/more complex (mental health) needs

There is an existing MOU between Reception Prisons and the Tasmanian Police Service to provide support in a range of activities as required, including:

- Transportation of prisoners to hospital when there are insufficient correctional officers on duty to meet minimum operational requirements.
- Onsite support from female Tasmania Police staff if there are no female correctional staff available to conduct processing searches of female prisoners.

Correctional staff detailed a highly collegial and supportive relationship with members of the Tasmanian Police Service, although acknowledged delays in responding to some requests for support given the staffing challenges being experienced by the Police Service. These MOUs are an important resource to support the operational needs of Reception Prisons, however may also suggest an opportunity to review staffing and recruitment processes to ensure operational needs can be primarily met through Reception Prison staffing.

Correctional staff detailed that historically there had been shortcomings in the nature and availability of support services for staff following incidents that could potentially result in distress. However, they reported that this has perceptibly improved over the previous 12-month period due to increased engagement of staff with programs including Mates Are There *for* Encouragement & Support (MATES), the Wellbeing Hub, and Employee Assistance Program. This improvement in the nature and availability of supports has also reportedly occurred alongside with a cultural shift within the organisation in which mental health is now treated akin to physical health. It was evident that the MATES program has been a key facilitator in supporting this cultural shift insofar as normalising a range of psychological responses to work-related stressors and modelling proactive and adaptive help-seeking behaviours. It also appears that satisfaction with these services following a recent death in custody has enhanced trust in the process, particularly in regard to the Wellbeing Hub that commenced operations with correctional staff in January 2022.

Commendation 5

Increasing access to fit-for-purpose mental health supports

Correctional staff reported satisfaction regarding their EAP Provider, and that this service is openly accessed by staff as needed although remains less utilised that other available mental health service resources. The comparatively lower levels of engagement with the EAP was reportedly due to perceived lower levels of context specific knowledge compared to colleagues within the MATES program. Correctional staff detailed that as a collegial network Reception Prisons provide a psychologically/socially “close” facility and reported that the management team are proactive and effective in ensuring the psychological wellbeing of staff following incidents and ensure that they spend time with the impacted staff member(s) in close proximity to the event. Reports of these interactions indicate that the management team have a good understanding of how to engage with impacted correctional staff to facilitate the needed support. Correctional staff reported knowledge of workers compensation processes and some senior staff have openly discussed their experiences with this process with their colleagues. This pattern of open discussion of accessing supports for health needs creates an environment of psychological safety,

enhancing the likelihood of other staff accessing these supports in the future as needed[59].

Commendation 6
Prioritisation of proactive mental health initiatives to support the mental health needs of staff have been implemented with evidence of uptake by staff

Continuity of Care

Both correctional and health staff reported difficulties in providing continuity of care for the mental health needs of prisoners within Reception Prisons. These difficulties spanned lack of access to case files and treatment histories if the individual was treated within the private sector, inability to identify if/when prisoners are subject to treatment orders, inability to provide access to existing psychotropic medications, and difficulties in facilitating access to treatment by existing providers whilst incarcerated. In addition to the risks associated with changing medications[60] or cessation of psychological interventions, staff reported that prisoners often experienced distress about these changes and that this impacted prisoner wellbeing and often resulted in prisoner dissatisfaction (and any associated maladaptive behaviours) being directed towards staff.

At present there is no mechanism available for health staff to facilitate assessment for a treatment order for prisoners remanded or residing in Reception Prisons. Given that untreated mental health conditions can increase risks of reoffending[61], it is recommended that an MOU is entered into to facilitate assessments for treatment orders as required. Further, greater capacity to support through-care for mental health

[59] Hunt, DF, Bailey, J, Lennox, BR, Crofts, M & Vincent, C 2021, 'Enhancing psychological safety in mental health services', *International Journal of Mental Health Systems*, vol. 15, no. 33. DOI: 10.1186/s13033-021-00439-1
[60] Shelton, D, Ehret, MJ, Wakai, S, Kapetanovic, T & Moran, M 2010, 'Psychotropic medication adherence in correctional facilities: a review of the literature', *Journal of Psychiatric Mental Health Nursing,* vol.17, no. 7, pp.603-13. DOI: 10.1111/j.1365-2850.2010.01587.x
[61] Brennan, PA, Mednick, SA & Hodgins, S 2000, 'Major mental disorders and criminal violence in a Danish birth cohort', *Archives of General Psychiatry*, vol. 57, no. 5, pp. 494 500. DOI: 10.1001/archpsyc.57.5.494

service provision was identified by health staff as a key need for prisoners and should be a priority within governance structures.

Recommendation 19

An MOU is entered into to facilitate assessments for treatment orders as required

At the time of evaluation, a new roster for correctional staff had been approved which accommodated increased overnight staffing and designated break times (this was not previously accommodated within the roster, meaning staff were not guaranteed breaks nor breaks of sufficient duration to eat or hydrate). This change is important to supporting mental health as rostered breaks allow for a sense of predictability and control over the environment, and respite and recovery from challenging interactions[62].

Commendation 7

Improved staff rostering to support positive mental health

The importance of organisational knowledge was exemplified by correctional staff identifying the mental health needs of known offenders whom have come into Reception Prisons on previous occasions. Organisational knowledge means that correctional staff are more able to proactively manage these offender mental health needs, protecting both the prisoner and staff. Further, the ongoing collegial relationships between correctional staff facilitate a psychologically safe and supportive environment in which individuals are well placed to recognise early warning signs of psychological distress.

[62] Lyubykh, Z, Gulseren, D, Premji, Z, Wingate, TG, Deng, C, Bélanger, LJ, & Turner, N 2022, 'Role of work breaks in well-being and performance: A systematic review and future research agenda', *Journal of Occupational Health Psychology*, vol. 27, no. 5, pp. 470-487. DOI: 10.1037/ocp0000337

The staff are highly experienced in their roles and are familiar with the organisational and cultural challenges associated with their roles within the custodial context. Reception Prison correctional staff were observed to interact easily with onsite prisoners and be responsive to their needs, referring to all by name and demonstrating knowledge of their unique needs. Correctional staff who were interviewed as part of the current evaluation were also able to self-identify a range of opportunities to further enhance the mental health and wellbeing of prisoners housed within Reception Prisons, and I encourage these staff to progress the ideas discussed within the context of the interviews.

Commendation 8

TPS staff involved in this evaluation demonstrated a high level of commitment to supporting the mental health needs of offenders currently housed in custodial settings in Tasmania

Health and correctional staff reported that prisoners would benefit from greater service provision from mental health resources available at the Risdon Prison Complex, which at this time due to resourcing constraints is largely constrained to involvement with SASH assessments and interventions. Health staff reported examples in which TSU involvement beyond SASH situations has resulted in enhanced psychological (and therefore onsite behavioural) outcomes for prisoners presenting with long-term psychological conditions (including anxiety and depressive disorders, sometimes related to childhood exposure to trauma) and emphasised the positive impacts that could be made if mental health outreach occurred more often. The health staff also detailed the strong links they have made with community health providers including General Practitioners and Pharmacists to support prisoners to retain engagement with needed health services upon release.

Recommendation 20

Increased provision of mental health supports and services for prisoners in Reception Prisons

Health staff also detailed the difficulties experienced by themselves and prisoners when prisoners are unable to continue with existing pharmacological prescriptions when incarcerated due to policies governing medication decisions. The Correctional Primary Health Services (CPHS) framework prohibits off-label prescriptions (i.e., situations in which a medication is prescribed in a manner inconsistent with the intended use within a given jurisdiction)[63], and similarly does not support prescriptions which do not meet threshold for therapeutic dosage, i.e., the amount of a given medication required to produce the desired or required symptom relief[64]. Prisoners who are unable to access their existing medications can quickly become distressed and their behaviour decline as a result of this. In addition to issues of medication titration, there are psychological sequelae of medication changes that impact the individual, other prisoners, and staff through increased exposure to distress and other associated behaviours. Additionally, it is often onsite health staff who are required to advise prisoners that their medications can no longer be accessed, and this can negatively impact the therapeutic relationship as responsibility for these decisions is often misplaced to the onsite health team. When therapeutic relationships are impaired, a prisoner's likelihood of engaging with the health team when needed is reduced, which in turn increases the risk of escalation of symptoms due to an inability to provide early intervention. Given that health staff are the primary conduit for mental health service provision, it is imperative that they are supported in their role to retain prisoner engagement with health services. The importance of health staff retaining prisoner engagement is recognised across a range of isolated and confined environments and an identified priority in these contexts.

Prisoner peer-support programs were identified by correctional staff as an important mental health resource for prisoners housed in Reception Prisons, however due to the high turnover of prisoners onsite the sustainability of the program can be challenging. There is a Red Cross peer mentorship training program being offered to prisoners at Risdon Prison Complex (RPC), and it is hoped that prisoners trained in that framework may be able to provide support to those in the Reception Prisons. Peer engagement

[63] Lücke, C, Gschossmann, JM, Grömer, TW, Moeller, S, Schneider, CE, Zikidi, A, Philipsen, A & Müller, HHO 2018, 'Off-label prescription of psychiatric drugs by non-psychiatrist physicians in three general hospitals in Germany', *Annals of General Psychiatry,* vol.17, no. 7. DOI: 10.1186/s12991-018-0176-4

[64] Hiemke, C, Baumann, P, Bergemann, N, Conca, A, Dietmaier, O, Egberts, K, Fric, M, Gerlach, M, Greiner, C, Gründer, G, Haen, E, Havemann-Reinecke, U, Jaquenoud Sirot, E, Kirchherr, H, Laux, G, Lutz, UC, Messer, T, Müller, MJ, Pfuhlmann, B, Rambeck, B, Riederer, P, Schoppek, B, Stingl, J, Uhr, M, Ulrich, S, Waschgler, R, & Zernig, G 2011, 'AGNP consensus guidelines for therapeutic drug monitoring in psychiatry: Update 2011', *Pharmacopsychiatry*, vol. 44, no. 6, pp. 195-235. DOI: 10.1055/s-0031-1286287

through these mentorship programs would facilitate an important source of social support[65] and pursuing the proposed engagement with RPC to facilitate this program within Reception Prisons is encouraged.

The demand for mental health services in Reception Prisons fluctuates depending on prisoner numbers and needs. However, it is not unusual for Therapeutic Services Unit (TSU) staff to be seeing in excess of 8 people in a single day. TSU staff report the most commonly presenting mental health needs of prisoners within Reception Prisons pertain to sleep difficulties (often associated with symptoms of substance withdrawals) and the impacts of isolation and confinement with limited access to fresh air and natural light (the impacts of which were detailed earlier in this report). There were concerns reported by staff that criminogenic needs are not being addressed for the medium-long term residents in reception prisons, increasing risks of reoffending in the future. A related concern was that life skills were not being addressed as they were not classified as criminogenic needs and therefore not being incorporated into therapeutic planning for this prisoner population. These reported conditions suggest an increased risk of recidivism may occur due to limited access to required mental health support services[66].

Health staff detailed that onsite roles are typically undertaken by experienced nursing staff who may hold a Registered Nurse qualification or Psychiatric Nurse qualification. Registered Nurses occupying these roles are not required to hold specialist training in mental health presentations. Although experienced registered nurses have a wealth of experience and skills to support the needs of prisoners housed in Reception Prisons, it is recommended that they be supported in their work through access to specific mental health training and continuing professional development to maximise their professional self-efficacy and provide for the complexity of mental health presentations and needs of prisoners. Health staff have developed processes to expedite medication needs for prisoners including obtaining dispensary histories from pharmacies to assist the prescribing doctors in expediting prescriptions, demonstrating commitment to prioritising prisoner medication and health needs. Overarchingly, health staff within the

[65] Fasihi Harandi, T, Mohammad Taghinasab, M, & Dehghan Nayeri, T 2017, 'The correlation of social support with mental health: A meta-analysis', *Electronic Physician*, vol. 9, no. 9, pp. 5212-5222. DOI: 10.19082/5212

[66] Skeem, JL, Winter, E, Kennealy, PJ, Louden, J & Tatar II, JR 2014, 'Offenders with mental illness have criminogenic needs, too: Towards recidivism reduction', *Law and Human Behaviour*, vol. 38, no. 3, pp. 212-224. DOI: 10.1037/lhb0000054

Reception Prisons are very highly valued, respected and regarded by correctional staff and prisoners; however, there is a perceived shortage of nursing staff rostered to support the growing mental health needs of a complex and diverse prison population.

Recommendation 21

Increased health staffing/resourcing for adult prisoners

Risdon Prison Complex

Risdon Prison Complex is the sole purpose-built custodial setting for medium-to-long term prisoners in Tasmania. The facility accepts offenders convicted under Tasmanian and/or Commonwealth legislation and provides services for prisoners classified across the spectrum from minimum to maximum security needs. A separate women's prison, the Mary Hutchinson Women's Prison is located adjacent to the RPC and for the purpose of this report will be considered as part of the RPC. Unless otherwise specified, information contained in this section of the report is relevant to all facilities within the RPC.

Commendation 9

The level of enthusiasm, passion, knowledge of criminogenic needs and commitment of all staff to addressing the mental health needs of prisoners housed within RPC

The level of enthusiasm, passion, knowledge of criminogenic needs and commitment to addressing the mental health needs of prisoners housed within RPC by all staff involved in this evaluation is highly commended. Multiple health, correctional and non-correctional staff were identified by name for their expertise and contributions to the mental health and wellbeing of both prisoners and colleagues.

An overarching limitation reported by correctional staff, health staff and prisoners housed within the Risdon Prison Complex related to insufficient infrastructure and resourcing to adequately support recovery and rehabilitation, particularly as it relates to psychosocial and mental health supports. Correctional staff, health staff and prisoners commented on the increased demand for mental health services available to prisoners within the Risdon Prison Complex. It was reported that common mental health presentations include trauma (often repeated), anxiety, depressive disorders, personality disorders, and substance use issues - with limited capacity and resourcing to manage or intervene in these contexts. Specific examples are detailed within this report, however do not provide an exhaustive list of these existing shortcomings.

Physical Environment

Correctional staff and prisoners reported that there is insufficient safe cell access within the Mary Hutchinson Women's Prison (MHWP), with one cell specifically designed for this purpose and any prisoner presenting with Level 1 or 2 SASH risk or acute mental health needs requiring transfer to the Crisis Support Unit (CSU) where they are housed alongside male offenders. At present, when there are multiple prisoners presenting with SASH risk (which is reportedly not an uncommon occurrence within the MHWP) correctional staff triage need for the safe cell and house other prisoners in one of three camera cells (7, 8, 9) in the same cell block (Wellington block). Cell 9 is equipped with two cameras and is preferred for SASH risk management when the single safe cell is unavailable. Cells 7 and 8 have single cameras which do not cover the shower area and are generally used as step-down cells as SASH risk reduces. When subject to SASH risk mitigation procedures in the safe cell, MHWP prisoners are afforded one hour outside the cell each day once the remainder of prisoners in the cell block have been locked down for the evening. Correctional officers detailed that introduction of the new High Risk Assessment Team (HRAT) process to the MHWP has increased capacity to manage SASH risk and potentially mitigate the need for transfer to CSU. In contrast, prisoners within the MHWP indicated ongoing dissatisfaction with the SASH risk management procedure. Given that prisoners involved in the SASH process are experiencing high levels of psychological distress this is not unexpected, however is worthy of further consideration in ongoing refinements to SASH risk management processes. It should also be noted that the MHWP prisoners who participated in the interviews associated with this evaluation had not engaged with the SASH process since the HRAT process had been implemented.

Given the reportedly increasing number, and complexity, of mental health presentations within the MHWP it is noteworthy that there is only one correctional officer assigned to the Wellington cell block to undertake duties associated with SASH, discipline, and the general population needs. Although it was reported that one further correctional officer will unofficially support the work undertaken in this cell block, official staffing plans stipulate the single officer appointment model. Related to this, there is a single correctional officer assigned to undertake HRAT activities. Single point dependencies create situations of risk regarding organisational knowledge and continuity of care processes, both of which are essential to adopting a consistent and sustainable best practice approach to support mental health needs of prisoners. There is one cell within the Wellington cell block that caters for prisoners of differing physical

abilities. It is recommended that staffing of the Wellington Unit be increased and additional staff trained in SASH and HRAT management processes to ensure provision of safe and sustainable services in this context. This need for additional staff resourcing spans all facilities and employment categories within the RPC and will be returned to within this section of the report. As such, the below recommendation should be considered relevant to all discussions regarding staffing within the RPC.

Recommendation 22

Urgently increase TPS staffing resources to protect prisoners and staff

A further recommendation regarding the physical environment within the RPC is to develop a designated inpatient unit for mental health presentations. Whilst it is recognised that this recommendation may be beyond scope given the current infrastructure constraints, provision of a purpose-built/designated inpatient facility within the RPC would better support the acute mental health needs of prisoners, and also assist in diverting prisoners identifying as female from needing to be collocated with prisoners identifying as male, particularly given that many prisoners identifying as female will be presenting with complex trauma histories that may include perpetration by male offenders.

Recommendation 23

TPS and CPHS develop a designated inpatient unit for mental health presentations

More broadly, staff within the health team and those within the therapeutic services unit are working towards providing a more therapeutic physical environment and are reviewing efforts in other jurisdictions such as the PIPES (psychologically informed planned environments) pilot in the United Kingdom[67]. Staff are commended on these

[67] Kuester, L, Freestone, M, Seewald, K, Rathbone, R & Bhui, K 2022, 'Evaluation of psychologically informed planned environments (PIPES): assessing the first five years', *Ministry of Justice Analytical Series,* London, <https://www.gov.uk/government/publications/evaluation-of-psychologically-informed-planned-environments>.

efforts to develop a more therapeutic climate to support prisoner recovery, and adopting this type of approach will further support meeting prisoner mental health needs.

Commendation 10

Staff are commended on their efforts to develop a more therapeutic climate to support prisoner recovery

Mental Health Training

Correctional staff reported actively seeking out professional development opportunities offered by the Tasmania Prison Service (TPS), as well as external training providers. Examples of this training have focused on understanding and responding to the needs of people presenting with Borderline Personality Disorder, vicarious trauma support skills and adopting trauma informed care practices into the prison setting.

There appeared to be awareness of the unique criminogenic needs of various prisoner profiles (e.g., women; those with cognitive deficits) by correctional staff working within the RPC setting. However, there was an expressed concern that many of the existing policies relating to behavioural classifications and processes have been designed for cis-gender male criminogenic needs and adopted, and in some cases adapted, for use with female prison populations. To provide a truly criminogenic approach to rehabilitation and mental health needs policies for diverse prisoner needs (e.g., women) should be developed rather than adapted. Related to this, consideration of neurodivergent and gender diverse presentations are not well accommodated within existing frameworks. Development of, and engagement with, best practice models catering to the needs of the Tasmanian adult prison population is recommended. This will require resources to be directed to the relevant operational units within the TPS to ensure the optimal model is implemented. Of importance is that the model is fit-for-purpose given the small jurisdiction and demographic needs within Tasmania which

means that any existing models employed in other jurisdictions/custodial contexts are less likely to meet requirements and necessitates development of a bespoke approach.

Recommendation 24

Develop and engage with, best practice models which cater to the needs of the Tasmanian adult prison population

Consistent with information provided by correctional staff within the Reception Prisons, staff within the RPC expressed a desire for increased training and support in identifying behavioural triggers and appropriate staff responses when dealing with prisoners. A primary focus of these discussions was on early identification and effective de-escalation techniques for prisoners. Although there is mixed evidence on the effectiveness of de-escalation training in isolation[68], there is sound evidence for the effectiveness of early intervention in managing mental health and behavioural distress in prison contexts and the role that this can play in both the short term as well as reducing recidivism risk[69].

There was reportedly minimal mental health specific training as part of the onboarding or continuing professional development of correctional staff, although correctional staff were able to identify the value of the training that is offered; there is also an existing relationship with Frontline Mind for the training of staff participating in the MATES program. Although there was no formally recorded data available, there was information to suggest that earlier career correctional officers may be at greater risk of mental health distress due to insufficient preparation and training, with more experienced staff indicating that at present the majority of skills relating to mental health (both the needs of staff, and those of prisoners) are learned 'on the job'. For this reason, the role of peer mentoring - in addition to formalised mental health training by

[68] Engel, RS, Mcmanus, HD & Herold, TD 2020, 'Does de-escalation training work?' *Criminology & Public Policy,* vol. 19, no. 3, pp. 721-759. DOI:10.1111/1745-9133.12467

[69] Evans, C, Forrester, A, Jarrett, M, Huddy, V, Campbell, CA, Byrne, M, Craig, T & Valmaggia, L 2017, 'Early detection and early intervention in prison: improving outcomes and reducing prison returns', *The Journal of Forensic Psychiatry & Psychology*, vol. 28, no. 1, pp. 91-107. DOI:10.1080/14789949.2016.1261174

mental health professionals - should be encouraged and supported, with recognition of its importance through formal workloading.

Recommendation 25

TPS encourage and support peer mentoring and embed in formal workloads.

Recommendation 26

Staff mental health training be embedded into onboarding and ongoing professional development frameworks

It is also recommended that reflective practice and other forms of peer supervision be integrated into workload for all staff, particularly those working specifically to support the mental health needs of prisoners residing within custodial contexts. As detailed when discussing the role of professional supervision within the AYDC context the overarching purpose of reflective practice is to provide a quality assurance framework for professional practice, as well as an opportunity for professionals to proactively and retrospectively reflect on challenging work-related experiences in a psychologically safe environment designed to validate, problem-solve and support best practice. As with other components of the required mental health practice framework, this reflective practice needs to be work-loaded to ensure that it is able to be engaged in and benefited from (noting the benefits to staff and residents). Access to high quality professional supervision that facilitates reflective practice has been demonstrated to enhance the effectiveness of provided care and in doing so improve the mental health outcomes of people for whom they are providing care[70]. The benefits of professional supervision are best achieved when the supervision is delivered by experienced professionals, which further reinforces the need to recruit and retain experienced staff to the RPC staffing profile. It is acknowledged that for many mental health staff employed within the RPC, professional supervision is a mandated registration requirement. Workloading and provision of supervision that facilitates reflective

[70] Snowdon, DA, Leggat, SG, & Taylor, NF 2017, 'Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review', BMC Health Services Research, vol. 17, no. 1, pp. 786-796. DOI: 10.1186/s12913-017-2739-5

practice can also be seen as a 'value adding' incentive to these roles which would otherwise need to be sourced (and potentially financed) independently - in this way, embedding supervision and reflective practice as a core work task may also assist with staff recruitment and retention.

Recommendation 27

Reflective practice and other forms of peer supervision be integrated into workload for all staff

When this recommendation was discussed with staff involved in mental health service delivery within RPC there was ready acceptance of the benefit of this approach, and staff readily identified how this could be implemented across Correctional Primary Health Services (CPHS), TSU and the Wilfred Lopes Centre. In addition to the documented benefits in the longer term for staff and prisoners alike, implementing a reflective practice framework would also provide for a sense of achievement in the shorter term and be an important source of positive reinforcement for the work being done by staff in this space.

Staff Mental Health

Due to the trust engendered through shared experiences and corporate knowledge, staff reported increased likelihood of engaging support from one another prior to engaging with external supports like the EAP and Wellbeing hub. It was reported that relatively few staff within the MHWP access the MATES program as there is no staff member from this facility within the MATES team, which can make it difficult to understand the facility specific differences in the work experience. For this reason, consideration should be given to appointment of a staff member in MHWP to the

MATES framework, although it is acknowledged that this would need to be with the consent and interest from the nominated staff member.

Recommendation 28

Consider recruiting a staff member in Mary Hutchinson Women's Prison to the MATES framework

Correctional staff reported that they felt well supported by the formal mental health staff employed within the prison service and that requests for prisoner intervention were responded to within relatively short time frames. Correctional and non-correctional staff spoke very highly of mental health staff across different service units within the RPC and expressed a desire for increased opportunities for interaction and education from these individuals. It is recommended that these requests be supported as not only will these opportunities increase mental health literacy beyond mental health staff, but these interactions also afford important opportunities for interdisciplinary learning and engagement that encourages more coordinated mental health supports for prisoners.

Recommendation 29

Support TPS staff requests for training from mental health staff to increase mental health literacy, interdisciplinary learning and more coordinated mental health support for prisoners

Risk Management Systems

It was reported that on any given day approximately 20-40 individuals within the RPC will be identified as presenting with risk of suicide or self-harm requiring activation of the SASH procedure. The existing SASH reporting process relies on an email system to make relevant parties aware that a prisoner is presenting with risk of suicide or self-harm. It is possible there are risks to this approach in that it relies on staff having capacity to check email regularly and respond to matters as they arise, particularly with reportedly increasing numbers of prisoners presenting with SASH risks. Processes for ensuring relevant staff are copied into this email in the event of staff absences (either

planned or unplanned) were not well documented, with staff explaining that a large number of people are included on the SASH emails to help protect against the risk of a prisoner not being adequately supported due to staff absences or email volume. Although this constitutes one method of trying to protect against the limitations of the existing system, it is not particularly robust as staff may be in the habit of not attending to these emails - believing that others will do so - and also risks breaching prisoner confidentiality. Having said this, there was no direct evidence that staff do not appropriately monitor and respond to SASH notifications.

Another important consideration regarding the SASH process is that due to staffing issues (detailed throughout this report), early career correctional officers may be involved in this process with limited training or support. The risks to prisoner safety and wellbeing resulting from these staffing limitations, as well as staff safety and wellbeing, cannot be underestimated and needs to be addressed as a matter of priority.

It was reported in a 2020 review that SASH processes within adult custodial contexts in Tasmania met national standards. The Acting Senior Psychologist is planning to undertake another review of the SASH process, followed by a review of the HRAT process, with particular emphasis on therapeutic jurisprudence approaches. A timeline was not provided for the development and implementation of this review process and given the identified staffing shortages the existing capacity for this review within the foreseeable future is considered limited.

Given the importance of this review in ensuring best practice approaches, which in turn assists in managing risks to the mental health and wellbeing of both prisoners and staff, addressing existing staffing shortages remains a priority in the RPC. Although it may be feasible to employ an external contractor to undertake this review, if engaged this individual will need a comprehensive understanding of custodial contexts; assessment and management of acute risk of self-harm and suicide; and be a qualified mental health professional with appropriate training, experience and skills to undertake this evaluation and develop evidence-informed recommendations.

Another consideration is that there was a reported belief (by staff and prisoners) that some prisoners engage the SASH process as a means to avoid being reintegrated into mainstream prison populations due to fears for their safety. With reported increasing levels of gang activity within the RPC and reported engagement by some prisoners in

intimidation ('standover' tactics), it is plausible that these fears may be justified in some instances. Fear is an understandable, and somewhat expected affective response to incarceration[71]. However, chronic and repeated experiences of fear can negatively impact mental health and wellbeing and result in maladaptive coping strategies including escapism[72] afforded through the SASH process. There was also evidence of relying on CSU cells for isolation of prisoners posing a risk to others (both staff and prisoners). In both instances, there is evidence of relying on already limited mental health infrastructure to manage broader behavioural issues within the prison context. There is no easy or proven method to address the above issues given that denial of access to safe cells can itself increase risk of self-harm and suicide in acutely distressed individuals. Further, isolation of dangerous prisoners causes a tension between safety of the prison community and opportunities for rehabilitation and/or assessment of readiness for release into the community. It is noted that a psychologist with specific knowledge and skills in gang and terrorism behaviour is working within a consultant role to support TPS in developing strategies to manage these issues and it is recommended that this psychologist continue to be involved in these matters to develop methods to address the above identified concerns.

Recommendation 30

A psychologist with specific knowledge and skills related to gang and terrorism behaviour continues to work with TPS in a consultant role to develop methods to manage prisoners posing a risk to others

Governance and Communication

Correctional staff reported that a review of the privileges system is currently underway to provide greater motivation towards optimal behaviour by prisoners. The planned review into the privileges system does not yet have a firm implementation or commencement date. It was reported that prisoners will not be a formal part of the review but will be invited to provide feedback. As detailed when considering the

[71] McCorkle, RC 1993, 'Fear of victimization and symptoms of psychopathology among prison inmates', *Journal of Offender Rehabilitation*, vol. 19, no. 1/2, pp. 27-42. DOI: 10.1300/J076v19n01_02

[72] Liebling, A & Arnold, H 2012, 'Social relationships between prisoners in a maximum security prison: Violence, faith, and the declining nature of trust', *Journal of Criminal Justice*, vol. 40, no. 5, pp. 413-424. DOI: 10.1016/j.jcrimjus.2012.06.003

behavioural incentives program within AYDC, whilst there are documented processes regarding reviews and evaluations, there was no formalised governance structures in this regard to ensure their occurrence. Evaluation of programs, incentives and other interventions are required to ensure they are meeting objectives and supporting positive behavioural change for prisoners and enhancing staff professional skills. A major inhibiting factor is around staff resourcing. There was clear awareness of the need to develop these frameworks and evaluation processes, however insufficient resourcing to do so. This is a further example of the importance of ensuring adequate staffing of the facility, as until this is remedied many of the recommendations contained within this report cannot be actioned.

It was detailed that at present there is no forum in which mental health staff from the community, prison and Wilfred Lopes Centre meet for case conferencing or other forms of communication related to prisoner mental health needs. The importance of information sharing across these contexts, as well as across mental health services within the TPS, was identified by the mental health taskforce as a key priority and is further recommended as a finding from the current evaluation. In response to this taskforce finding, a formalised process for information sharing regarding prisoner mental health within the prison was established with increased communication occurring between Health and the TPS through MDT and Risk Intervention Team Communication (RITCOM) meetings. Staff reported these meetings to be a reasonable compromise to issues highlighted by the Taskforce. Staff also detailed that complete information sharing between TPS and CPHS is not always needed nor appropriate (and in some cases is restricted by National Law regarding client/patient confidentiality). An example provided by staff was that although correctional staff need to be aware of risk of harm to self or others posed by a prisoner, the correctional staff do not need to be provided extensive information regarding presenting issues and diagnoses unless the prisoner has consented for this information to be shared or it is directly related to meeting their mental health needs. Similarly, it was detailed that mental health staff do not need to know custodial information regarding a prisoner unless this is directly relevant to safety or treatment planning.

It was reported that there have been concerted efforts to increase connections and communication between prison mental health services with Adult Community Mental Health and Child and Adolescent Mental Health Services to improve mental health service provision and continuity of care to those subject to custodial sentences. This

process remains in its early stages and staff are actively problem-solving challenges and barriers to this process. At the time of the evaluation, a range of formalised MOUs were being progressed to ensure governance around engagement with external service providers.

The current data recording systems do not directly speak to each other, and also are somewhat cumbersome on staff to coordinate. Records of service, nature of service and other metrics that can support cases for additional resourcing cannot be readily obtained from existing data recording processes. Additionally, there are security risks (pertaining to both unauthorised access, as well as inability to access in the case of a staff member being unexpectedly unavailable) given the diversity of systems and programs being used to record data at this time. Development of a streamlined process in this regard not only facilitates a better ability to triangulate data pertaining to offender criminogenic needs and program outcomes, but also in a manner that does not unduly burden staff affiliated with the program. Such changes would also facilitate an increased ability of staff to more readily monitor program effectiveness on a day-to-day, or program-to-program basis and may also provide for a more robust approach to SASH and other risk related notifications. These data management systems can (and should) ensure stratified access so that information is restricted based on staff role.

More broadly, a fit-for-purpose data management system can also assist with communication within and beyond the custodial context and can provide a secure repository for information received from the community that will assist with providing for prisoner mental health needs, as well as facilitating ready collation of data to support reintegration into community mental health supports following release from prison.

Recommendation 31

Development of a structured, standardised and integrated system to assist in record management for offender mental health data

Again, consistent with the recommendations identified regarding behavioural incentive programs within AYDC, there is an identified need for involvement of prisoner representation/involvement to ensure that lived experience is integrated into decision

making. It is evident that prisoners have valuable insights to share with RPC staff, including desirable incentives to promote adaptive behaviour. The effectiveness of behavioural support programs is contingent on the reinforcements being relevant, achievable, and valuable. As such, the success of the privileges system is contingent on resident input regarding the process, particularly reinforcers being used as a motivator for positive behaviour. It is acknowledged that there are prisoner representatives appointed to engage with RPC staff, however it was reported that meetings had not been held for more than 12 months due to the impacts of COVID-19 and ongoing staffing shortages. Prisoner representatives were disappointed in the limited opportunities to engage with correctional staff to address perceived needs, particularly as they indicated when the meetings were previously being held that staff were collaborative and receptive to prisoner feedback. It is therefore recommended that staffing within RPC be addressed to facilitate resumption of staff-prisoner feedback processes.

Prisoners detailed that a lack of access to education, training opportunities, and structured activities in general is negatively impacting mental health, including preparation for release (and hope of success in non-offending following release). Although there was a recognition that access to training and education were negatively impacted by COVID-19 restrictions, there was concern that these opportunities had not resumed. Further, prisoners identified that given the lack of structure to their days they were afforded an opportunity to engage with self-development and felt that this opportunity was being missed. There was also concern that a range of education and training focused on family violence, anger management, and other psychological presentations were not available to those housed within the medium security RPC site. Engagement in activities that provide a sense of purpose and meaning have been demonstrated to improve psychological resilience, decrease risk of suicide and self-harm, increase mental health and wellbeing, and increase motivation and engagement in prosocial behaviour[73] [74]. It is acknowledged that there is greater scope for engagement in activities within the Ron Barwick Prison as this is predominantly a working prison with opportunities to engage with vegetable processing, woodwork (with

[73] Woods, D, Leavey, G, Meek, R & Breslin, G 2020, 'Developing mental health awareness and help seeking in prison: a feasibility study of the State of Mind Sport programme', *International Journal of Prisoner* Health, vol. 16, no, 4, pp, 403-416. DOI:10.1108/ijph-10-2019-0057

[74] Mueller, S, Hart, M & Carr, C 2021, 'Resilience building programs in U.S. corrections facilities: An evaluation of trauma-informed practices in place', *Journal of Aggression, Maltreatment & Trauma,* vol. 32, no. 1/2. DOI:10.1080/10926771.2021.2008082

the Ron Barwick facility currently fulfilling a contract to produce bed frames) and peer support programs; employment positions are available to medium security prisoners in the prison laundry and tailor shop.

It was evident from staff within the Programs Unit and Therapeutic Services Unit, as well as correctional staff, that there is a strong motivation to increase prisoner access to self-development opportunities as a method for supporting adaptive and prosocial behaviour and enhancing mental health and wellbeing. However, it was again detailed that staffing shortages and resourcing limitations - including, but not limited to, difficulties with repeated and ongoing lockdowns and difficulties recruiting to positions - have reduced capacity for these resources to be offered. It was further detailed that these resources were not deemed core operations, which were at times the only tasks able to be reliably staffed within the RPC. This is another example of the far-reaching impacts the current staffing shortages are having on prisoners and staff. Given the risks to both short and long-term mental health outcomes for prisoners who are not afforded access to necessary and desired self-development opportunities, it is recommended that urgent action be taken to address current staffing issues within the RPC.

There are shortcomings with the existing fatigue management policies, particularly following exposure to a potentially traumatic event. It is recommended that existing policies are reviewed and updated to ensure that the mental health and wellbeing needs of staff working in a complex extreme and unusual environment typified by exposure to potentially traumatic events are appropriate to the context. From a workers' compensation perspective senior correctional staff detailed a positive correlation between PTSD/work-related stress claims and correctional staff who had worked in excess of 1000 hours of overtime. Staff work rosters are currently being reviewed to address risks associated with long work hours (with reportedly high rates of non-compensated overtime currently occurring), night shifts and overtime. It is likely that the levels of overtime are being exacerbated due to staffing shortages across all contexts (correctional, non-correctional and health staff) and there was evidence of staff working long hours to try and minimise impacts of staffing shortages on colleagues and prisoners. Multiple staff across different contexts within the RPC identified that there is a need to develop, review and revise governance structures to better account for mental health and wellbeing needs of staff and prisoners. Health staff in particular identified a range of governance structures that require development and review, as

did staff within TSU and the Programs Unit. These identified governance priorities were detailed in the presentation provided by supervisory/managerial staff involved in mental health service delivery within the RPC, and it is strongly recommended that these initiatives be progressed as a matter of priority. It is recommended that these governance reviews are prioritised and workloaded appropriately to ensure meaningful engagement and associated outcomes. Given the repeatedly identified staffing shortages, there may be a role for an external consultant to assist with/undertake this governance review. However, as previously identified, any external consultants will need a sound understanding of both the custodial context and mental health needs for this to be an effective use of time and resources.

Recommendation 32

Existing policies are reviewed and updated to ensure that the mental health and wellbeing needs of staff working in a complex extreme and unusual environment typified by exposure to potentially traumatic events are appropriate to the context

Recommendation 33

Develop and review governance structures to better account for mental health and wellbeing needs of staff and prisoners as a matter of priority, ensuring these reviews are workloaded appropriately to ensure meaningful engagement and associated outcomes

Prisoner Mental Health Needs

A primary focus of prisoners who were interviewed as part of the current inspection focused on access to health care, and the link between mental and physical health. It was reported that access to a range of medical services was not consistent, with delays exacerbated as a result of staffing shortages associated with the impacts of COVID-19. It was reported that in some instances prisoners with access to appropriate finances have self-funded their own medical treatment with external practitioners.

Access to dental services was particularly highlighted with reports of prisoners existing with high levels of oral pain for up to 18 months before receiving intervention.

Prisoners reported ongoing stigma associated with disclosures of mental health difficulties, and that disclosures of distress or requests for help from correctional staff are discouraged within prisoner culture and may be interpreted as a sign of weakness, increasing risk of being targeted for physical attack by others in the prisoner population. This is not a unique situation within RPC and is well documented in other custodial contexts[75]. It was reported that there is a perceived high risk of being targeted for assault or other antisocial behaviour for any prisoners who transfer from the mental health unit into the medium security population. This is seen as particularly problematic as in order to access TSU services specific requests need to be made through correctional staff given that TSU staff do not routinely walk through the yards or have a physical presence in medium security. Prisoners reported that they believed they identified signs of deterioration in prisoner mental health (e.g., declines in personal hygiene, antagonistic behaviour towards others, etc.) well before correctional staff acted on these. It is not surprising that prisoners would recognise signs of deterioration in mental health earlier than correctional officers given their regular engagement with peers, and likely efforts to conceal deteriorations given perceived risks to physical safety. These comments also align with feedback from correctional officers regarding a desire for training in early identification of declines in prisoner mental health and wellbeing.

Cultural change, which is what is required to address the identified stigma and perceived risks regarding mental health disclosures detailed by prisoners is not easily achieved, particularly in situations where people feel psychologically unsafe[76]. Cultural change requires engagement from all key stakeholders (including prisoners and staff) and a recognised benefit for the proposed/desired change. However, there is emerging evidence regarding the development of therapeutic climates within prison contexts that may be useful to guide these approaches. Therapeutic climate approaches advocate that the prison itself becomes an environment in which prisoners are able to learn and

[75] McCorkle, RC 1993, 'Fear of victimization and symptoms of psychopathology among prison inmates', *Journal of Offender Rehabilitation*, vol. 19, no. 1/2, pp. 27-42. DOI: 10.1300/J076v19n01_02

[76] Byrne, J, Taxman, F & Hummer, D 2005, 'Examining the impact of institutional culture (and culture change) on prison violence and disorder: A review of the evidence on both causes and solutions', Paper presented at the 14th World Congress of Criminology, Philadelphia, PA.

practice skills to address their offending and antisocial behaviours[77]. Early stages of this approach encourage prisoners to engage in adaptive and prosocial skills with therapeutic staff in-session, and with correctional staff outside of session. It also involves correctional officers modelling these adaptive and desired behaviours. Existing research findings suggest that adopting therapeutic climate approaches have resulted in improvements in prison culture across a range of prisoner presentations, including typically vulnerable groups like sex offenders[78]. Given the reported success of shifting staff culture towards mental health stigma and supports within custodial contexts in Tasmania, there is promise for facilitating change within the prisoner population also. This change will require focused training and support for correctional officers so that they can meaningfully engage with the development and sustainment of a therapeutic climate within RPC. This approach will require additional resourcing for training, ongoing professional development and staffing to facilitate the desired outcomes.

Recommendation 34
Implement a formal professional development framework in RPC to support implementation and consolidation of evidence-based, contemporary practices relating to therapeutic climate and therapeutic jurisprudence

Staff detailed that the designated mental health units within RPC are not able to accommodate the number of prisoners who require targeted mental health supports. Prisoners waiting for access to this specialist mental health unit are currently housed in CSU contexts, which essentially constitutes a form of isolation given they are housed in an isolated cell except for brief periods of access to a secure exercise area - again separated from other prisoners. Both correctional and non-correctional staff independently detailed a desire for the existing CSU cells to be increased in number and made more therapeutic (e.g., facilitative of prisoners being able to move in and out

[77] Stasch, J, Yoon, D, Sauter, J, Hausam, J & Dahle, KP 2018, 'Prison climate and its role in reducing dynamic risk factors during offender treatment', *International Journal of Offender Therapy and Comparative Criminology*, vol. 62, no. 14, pp. 4609-4621. DOI: 10.1177/0306624X18778449
[78] Blagden, N. Winder, B & Hames, C 2016, '"They treat us like human beings" - Experiencing a therapeutic sex offenders prison: Impact on prisoners and staff and implications for treatment', *International Journal of Offender Therapy and Comparative Criminology*, vol. 60, no. 4, pp. 371–396. DOI: 10.1177/0306624X14553227

of cells, engage with other prisoners in CSU and staff for support, increased access to natural light and outdoor facilities) to assist in the mental health recovery process. Discussions with staff regarding the existing CSU processes demonstrated a genuine concern regarding identified shortcomings. Staff expressed hope that reduced prisoner numbers following the opening of the SRC would relieve some of the existing pressures on CSU, however they also acknowledged that with increasing numbers of prisoners presenting with mental health needs that existing infrastructure would remain inadequate. This is a further example of the limitations of existing infrastructure in meeting the mental health needs of prisoners within Tasmanian custodial contexts. Although not easily resolved, these limitations should be considered in redevelopments of the physical environments used by custodial contexts.

During the evaluation the ‘dry cell’ management procedure was detailed by both correctional and non-correctional staff. Prisoners within RPC are accommodated within the dry cell if correctional staff receive intelligence indicating that a prisoner has concealed contraband internally. The dry cell facilities allow for correctional staff to monitor all body excretions and obtain any contraband that may be held internally by the prisoner.

The dry cell is contained within the RPC reception unit. The lights are left on permanently in this cell, and the cell is bounded by a transparent wall facing into the hallway so that correctional officers can maintain observations at all times for both prisoner safety and offence related reasons. The lights were reported to be required to remain on to facilitate observation via the camera system overnight. Prisoners within the dry cell are provided pencil and paper, as well as books, upon request. The prisoner is not able to access any television or other technology whilst in the dry cell. It was reported that dry cell management of prisoners is for periods of up to 72 hours, although the duration may be less if prisoners concede the contraband or intelligence indicates that they do not have concealed contraband. Health staff are reportedly consulted prior to the prisoner being allocated to the dry cell to ensure that the prisoner is physically healthy and to explain the risks associated with internally concealing contraband. The above process represents one of the challenges inherent in managing mental health needs within a custodial context. Constant exposure to artificial light and minimal privacy does not align with strategies designed to optimise mental health and wellbeing. It is recommended that Health staff liaise with correctional staff to ensure

that mental health screening and monitoring is considered as part of the dry cell management procedure.

Recommendation 35

Health staff liaise with correctional staff to ensure that mental health screening and monitoring is considered as part of the dry cell management procedure

Another challenge within custodial contexts pertains to providing for the mental health needs of older and very old adults. Division 7 within the RBP caters for prisoners who are unable to reside with the general population due to the impacts of age on their capacity to engage in activities of daily living and remain physically and psychologically safe. Essentially, infrastructure and staffing within general populations are not able to accommodate these older prisoners, many of whom have entered end-of-life management approaches to their remaining sentence. Although the number of older and very old adult prisoners is comparatively low compared to the general prisoner population, they do present with unique mental health needs including those associated with ageing and end of life processes which must be navigated largely in the absence of pre-existing social support and community/familial networks. There is increasing research focused on the mental health and wellbeing needs of older adults within custodial contexts[79], most of which identifies the need for social support and support in developing adaptive coping strategies to manage challenges associated with ageing including grief and loss[80]. There was no available documentation or policy to review regarding the management of mental health needs of older and very old prisoners, and it is recommended that this be addressed as a matter of priority. Additionally, this policy should also detail processes for supporting older and very old prisoners presenting with cognitive decline or neurodegenerative conditions including dementias or acquired brain injuries, particularly given evidence that those in custodial contexts may be more likely to have experienced (repeated) head injury, acquired brain

[79] E.g. Di Lorito, C, Völlm, B & Dening, T 2018, 'Psychiatric disorders among older prisoners: a systematic review and comparison study against older people in the community', *Aging & Mental Health*, vol. 22, no.1, pp. 1-10. DOI: 10.1080/13607863.2017.1286453

[80] E.g. Maschi, T, Viola, D, Morgen, K & Koskinen, L 2015, 'Trauma, stress, grief, loss, and separation among older adults in prison: the protective role of coping resources on physical and mental well-being', *Journal of Crime and Justice*, vol. 38, no. 1, pp. 113-136. DOI: 10.1080/0735648X.2013.808853

injuries, have a history of substance misuse and a range of other demographic factors correlated with increased risk of cognitive decline[81].

Recommendation 36

As a matter of priority, develop policy or documentation regarding the management of the mental health needs of older and very old prisoners

An overarching observation within the current evaluation was the reliance on reactive, as opposed to proactive/early intervention models of mental health service delivery within custodial contexts. There was clear recognition of this approach and its limitations detailed by staff across all custodial contexts and occupational categories. As detailed elsewhere, this outcome is due - at least in part - to staffing shortages that limit the ability to engage more proactive methods of mental health management.

Health staff detailed that as the PACER (Police, Ambulance, and Clinician Early Response) response is introduced to custodial contexts, they expect there will be increased capacity for early diversion practices for mental health presentations. Given the clearly evidenced benefits of early intervention in managing and reducing the burden of mental health distress (in prisons and beyond)[82], adopting early intervention models of mental health care are further recommended for implementation.

Recommendation 37

Adopt early intervention models of mental health care

Staff Resourcing

Staff shortages were reported across all employment categories at the RPC and have been repeatedly referred to within this report given the far-reaching impacts on capacity

[81] E.g. Maschi, T, Kwak, J, Ko, E, & Morrissey, MB 2012, 'Forget me not: Dementia in prison', *The Gerontologist*, vol. 52, no. 4, pp. 441-451. DOI: 10.1093/geront/gnr131

[82] Evans, C, Forrester, A, Jarrett, M, Huddy, V, Campbell, CA, Byrne, M, Craig, T & Valmaggia, L 2017, 'Early detection and early intervention in prison: improving outcomes and reducing prison returns', *The Journal of Forensic Psychiatry & Psychology*, vol. 28, no, 1, pp. 91-107. DOI: 10.1080/14789949.2016.1261174

to meet the mental health needs of prisoners and staff. The need for additional staffing was well recognised by those who participated in the interviews associated with the current mental health evaluation. There are plans to recruit additional staff, although ongoing difficulties with recruitment were noted across all staffing contexts. Until this staffing issue is resolved the planned transition from reactive mental health management to a case management approach to supporting the mental health needs of prisoners will not be realised. Given the ongoing difficulties recruiting to positions, particularly those within units providing mental health services, it is imperative to implement innovative strategies to attract and retain high quality candidates. These strategies may include alternative employment models such as conjoint appointments with Tasmania Health Service/Forensic Mental Health Services, part time employment or consultancies with private practitioners, or as an interim measure engage graduate internships and collaborations with training providers such as Social Work, Nursing, Medicine, Counselling, and Psychology at the University of Tasmania. Further, engaging strategies and incentives to make RPC an employer of choice is also warranted, as occupational fulfilment and satisfaction can be stronger motivators than financial incentives alone. One point of difference that may be appealing in this context is an opportunity to engage in practice-based research and innovation. It was reported that the Research Unit within RPC provides an avenue for such research to occur, however in practical terms this unit is insufficiently staffed, and existing staff research interests and opportunities are unable to be pursued. Adequate resourcing of the Research Unit is beneficial on multiple levels from providing an avenue for increased staff job satisfaction, to facilitating context-specific research that informs practice both at the local level (i.e., RPC) and other custodial contexts. Becoming a leader in research creates an innovative point of difference that may assist in recruitment and retention of high-quality candidates, as well as diversifying career development opportunities for staff.

Recommendation 38

Additional resourcing of existing research units/engaging with partners to undertake robust targeted mental health research focused on custodial contexts

Despite correctional staff reportedly undertaking high amounts of overtime to meet basic operational needs, it was detailed that there were repeated instances in which lockdowns were implemented due to staffing shortages. The impacts of lockdowns were detailed when discussing their occurrence within the AYDC context. As a brief reminder, the impacts of isolation and confinement on mental health can result in both positive and negative outcomes which are largely dependent on the interaction between individual, interpersonal and organisational influences. Within the context of the current evaluation, prisoners did not identify positive experiences associated with the enforced lockdowns. However, they did acknowledge negative impacts identified in other isolated and confined environments including increased frustration, depressive symptoms, anger, irritability and general declines in mental health and wellbeing. Further, as detailed previously in this report, social isolation limits the opportunity of prisoners to practice more adaptive behaviours that are required to facilitate long-term positive behaviour change that can support their success following release. It is acknowledged that staffing shortages appear to have been exacerbated by the impacts of COVID-19, however, remains a particular barrier to achievement of the range of strategies and mental health initiatives detailed by staff. Health staff identified a range of mental health related governance issues, policies, procedures and research agendas that are priorities within the custodial context but at this time cannot be pursued due to resourcing limitations. These priorities included, but were not limited to, developing a position statement on involuntary admissions/treatment orders within custodial contexts and drug and alcohol intervention needs within custodial contexts.

Staff across all contexts within the RPC (health, correctional and non-correctional staff) identified the need for more intervention and education programs to be made available to prisoners during their custodial sentence. The programs recommended by staff varied by context however consistent themes focused on family violence, drug and alcohol use, parenting skills, anger management, resilience, and interventions targeting criminogenic needs that relate to mental health. At present there are currently 9 full time equivalent staff (with an additional two staff on workers compensation leave) within the Programs Unit which is budgeted for 19 full time equivalent positions which further limits access of prisoners to evidence-informed mental health and behavioural intervention programs.

Of the three standard programs available within the RPC (New Directions for sexual offenders; Violence Prevention/Family Violence Offender Intervention Program; and

Dialectical Behaviour Therapy within MHWP), it was reported that only the New Directions program has been consistently offered due to legislation requiring some offenders to complete this program as part of their custodial sentence. Additionally, the New Directions and Violence Prevention/Family Violence Offender Intervention Program are currently only available to prisoners within the Ron Barwick Prison. In addition to the challenges to program delivery associated with staffing limitations, further challenges are incurred as a result of sentencing processes. At present unsentenced prisoners and those with shorter custodial sentences (i.e., those less than 6 months) are unable to engage with programs designed to target criminogenic needs due to programs requiring a minimum engagement period that exceeds their sentence or relatively rapid movement through differing levels of accommodation (i.e., security classifications) within the RPC. In addition to the proposed 12-hour resilience training programs to be offered within the SRC, identification and implementation of evidence-based/evidence-informed targeted intervention programs of shorter duration is also recommended for those prisoners within the RPC serving sentences of shorter duration. Providing access to these resources can improve the mental health and wellbeing of prisoners whilst in the RPC and also reduce the risk of recidivism following release, given the relationship between mental health distress and offending/recidivism risk[83].

Recommendation 39

Identify and implement evidence-based/evidence-informed targeted intervention programs of shorter duration for prisoners within the RPC serving sentences of shorter duration

It was also reported that increasing numbers of prisoners are accessing National Disability Insurance Scheme (NDIS) supports which indicate a cohort of individuals with chronic physical and mental health needs, as well as cognitive impairments (that may pertain to intellectual disability or acquired brain injury). This demonstrates a growing need for specialist services including psychologists, counsellors, and

[83] Yukhnenko, D, Blackwood, N & Fazel, S 2020, 'Risk factors for recidivism in individuals receiving community sentences: a systematic review and meta-analysis', *CNS Spectrums,* vol. 25, no. 2, pp. 252-263. DOI:10.1017/s1092852919001056

occupational therapists to meet the mental health needs of prisoners accommodated within the RPC. Relatedly, increased provisions for reintegration planning and support will also be needed to address the diverse and increasingly complex mental health needs of prisoners transitioning into the mainstream community following release from prison.

Conclusion

This report provides an evaluation of mental health services within Tasmanian custodial contexts. The approach to the evaluation constitutes a mixed-methods research design, and triangulation was used to integrate data from multiple sources to draw conclusions regarding the efficacy of mental health strategy and interventions in Tasmanian custodial contexts.

The objectives of this report were to:

1. Identify instances of best practice in supporting the mental health needs of those living and working within custodial contexts in Tasmania
2. Identify opportunities to further enhance mental health services offered within Tasmanian custodial contexts
3. Inform recommendations based on the above

As detailed throughout the report, a series of commendations and recommendations have been developed based on identification of instances of best practice as well as opportunities to further enhance mental health services offered within Tasmanian custodial contexts. These commendations and recommendations pertain to all custodial contexts in Tasmania unless otherwise specified. These commendations and recommendations are listed again below for ease of reference:

Commendations

Commendation 1	All staff engaged in this evaluation process reported and were observed to provide high levels of collegial support to one another, which creates an environment of psychological safety to protect the mental health of staff.	
Commendation 2	AYDC staff are highly engaged and resident focused	Page 76
Commendation 3	AYDC staff are engaging in practices designed to provide a more therapeutic and rehabilitative context for residents	Page 89

Commendation 4	Decisions regarding SASH accommodations are made collaboratively between correctional staff, health staff, and prisoners (where appropriate)	Page 105
Commendation 5	Increasing access to fit-for-purpose mental health supports	Page 110
Commendation 6	Prioritisation of proactive mental health initiatives to support the mental health needs of staff have been implemented with evidence of uptake by staff	Page 111
Commendation 7	Improved staff rostering to support positive mental health	Page 112
Commendation 8	TPS staff involved in this evaluation demonstrated a high level of commitment to supporting the mental health needs of offenders currently housed in custodial settings in Tasmania	Page 113
Commendation 9	The level of enthusiasm, passion, knowledge of criminogenic needs and commitment of all staff to addressing the mental health needs of prisoners housed within RPC	Page 117
Commendation 10	Staff are commended on their efforts to develop a more therapeutic climate to support prisoner recovery	Page 120

Recommendations

Ashley Youth Detention Centre

Recommendation 23	TPS and CPHS develop a designated inpatient unit for mental health presentations.	Page 119
Recommendation 24	Develop and engage with, best practice models which cater to the needs of the Tasmanian adult prison population	Page 121
Recommendation 25	TPS encourage and support peer mentoring and embed in formal workloads	Page 122
Recommendation 26	Staff mental health training be embedded into onboarding and ongoing professional development frameworks	Page 122
Recommendation 27	Reflective practice and other forms of peer supervision be integrated into workload for all staff	Page 123
Recommendation 28	Consider recruiting a staff member in Mary Hutchinson Women's Prison to the MATES framework	Page 124
Recommendation 29	Support TPS staff requests for training from mental health staff to increase mental health literacy, interdisciplinary learning and more coordinated mental health support for prisoners	Page 124
Recommendation 30	A psychologist with specific knowledge and skills related to gang and terrorism behaviour continues to work with TPS in a consultant role to develop methods to manage prisoners posing a risk to others	Page 126

Recommendation 31	Development of a structured, standardised and integrated system to assist in record management for offender mental health data	Page 128
Recommendation 32	Existing policies are reviewed and updated to ensure that the mental health and wellbeing needs of staff working in a complex extreme and unusual environment typified by exposure to potentially traumatic events are appropriate to the context	Page 131
Recommendation 33	Develop and review governance structures to better account for mental health and wellbeing needs of staff and prisoners as a matter of priority, ensuring these reviews are workloaded appropriately to ensure meaningful engagement and associated outcomes	Page 131
Recommendation 34	Implement a formal professional development framework in RPC to support implementation and consolidation of evidence-based, contemporary practices relating to therapeutic climate and therapeutic jurisprudence.	Page 133
Recommendation 35	Health staff liaise with correctional staff to ensure that mental health screening and monitoring is considered as part of the dry cell management procedure	Page 135
Recommendation 36	As a matter of priority, develop policy or documentation regarding the management of the mental health needs of older and very old prisoners	Page 136

In conclusion, evidence obtained in the context of the current evaluation of mental health services and supports within Tasmanian custodial contexts identified a range of opportunities for improvement, with a majority of recommendations contingent on addressing existing deficits in staffing and infrastructure resourcing. Despite these challenges, it is important to acknowledge and commend the efforts of staff within each custodial setting to identify and respond to mental health needs. There was clear evidence of enthusiasm, passion, knowledge of criminogenic needs and commitment to addressing the mental health needs of residents of custodial contexts by all staff involved in this evaluation.

Adult health care inspection 2023

Appendix 3

Report by Dr Edward Petch - physical health care and substance use management

Office of the Custodial Inspector
Tasmania

Tasmanian custodial inspection report

Physical health care, alcohol and other drugs management

30 January – 10 February 2023

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MBBS BSc MSc FRCPsych DFP Dip Crim FRANZCP MBA GAICD

2023

Contents

Acronyms

ADS	Alcohol and Drug Service
AOD	Alcohol and Other Drugs
AYDC	Ashley Youth Detention Centre
CPHS	Correctional Primary Health Service
CSU	Crisis Support Unit
DoH	Department of Health
DoJ	Department of Justice
DRT	Dedicated Response Team
FTE	Full Time Equivalent
GP	General Practitioner
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRP	Hobart Reception Prison
LGH	Launceston General Hospital
LRP	Launceston Reception Prison
MHWP	Mary Hutchison Women's Prison
MOU	Memorandum of Understanding
ORT	Opioid Replacement Therapy
RBP	Ron Barwick Prison
RHH	Royal Hobart Hospital
RPC	Risdon Prison Complex
SLA	Service Level Agreement
SMT	Senior Management Team in the Tasmania Prison Service
SRC	Southern Remand Centre
THS	Tasmanian Health Service
TPS	Tasmania Prison Service

Recommendations

The recommendations are made in good faith in a genuine desire and hope that they will be useful for the Tasmania Prison Service (TPS), Ashley Youth Detention Centre (AYDC) and healthcare providers and will help to improve the services that are delivered.

Introduction

1.	TPS and Correctional Primary Health Services (CPHS) develop a set of principles for the delivery of healthcare services and monitor their services against these principles.	see page 178

Access to care

2.	If prison lockdowns are urgently required for regular training, they occur a maximum of one day per month.	see page 180
3.	During prison lockdowns, each prisoner who is confined to their cell is considered to be in a state of segregation.	see page 183
4.	Prisoners in segregation have at least one hour out of their cell every day in line with the *Corrections Act 1997* and international humanitarian obligations.	see page 184
5.	People who are mentally ill are not subject to segregation unless it is by a specific order, such as disciplinary segregation or medical segregation.	see page 185
6.	People in segregation should be medically reviewed according to international guidelines.	see page 186
7.	CPHS staff receive the appropriate training to be permitted to walk within the maximum and medium security parts of the prisons unaccompanied.	see page 186
8.	CPHS ensure appropriate standards relating to waiting times to see doctors are set and audited in a rolling cycle.	see page 187
9.	The business case for expansion of the available staff base with the opening of Southern Remand Centre (SRC) is reviewed and resubmitted.	see page 189

10.	Staff on workers compensation considered to be permanently incapacitated should be removed from the TPS staffing establishment to enable recruitment into their vacant full time equivalents (FTEs).	see page 190
11.	TPS and the unions are both encouraged to reach agreement about staff numbers required to fully operate the prison and the threshold for when lockdowns are required on the basis of staff shortages.	see page 191
12.	TPS Senior Management Team (SMT) seeks external advice from a management consultant regarding the development of a change management process to replace the command and control culture into a more contemporary and effective management approach.	see page 193
13.	TPS SMT seek external advice from a strategic human resources management consultant regarding the development of an effective staff recruitment and retention strategy.	see page 195
14.	The Director of Corrective Services considers granting prisoners in segregation during lockdowns special management days to the equivalent time they have been in lockdown and that this time is remitted from their sentence.	see page 196

Governance and administration

15.	Training be provided for correctional staff about the role of health staff and vice versa.	see page 198
16.	Review the Letter of Intent between the Department of Health and the Department of Justice, and this to be shared with all staff from CPHS and TPS.	see page 199
17.	TPS to bring all standard operating procedures and Director's Standing Orders relating to healthcare services up to date and keep them under review.	see page 204
18.	CPHS Clinical Speciality group needs to meet at least six times per year.	see page 205
19.	CPHS acknowledge patients' medical requests and give a date by when they will be actioned or reasons why they will not.	see page 206
20.	Alert patients of their medical appointments without announcing it to the entire unit.	see page 207

21.	CPHS acknowledge the receipt of complaints and provide a date by which they will be investigated and if appropriate, actioned.	see page 209
22.	Feed findings from complaints into the Clinical Speciality Group for introduction into the clinical improvement process.	see page 209
23.	CPHS to establish a regular meeting with the Health Complaints Commissioner to discuss complaints, trends and outcomes.	see page 209
24.	All CPHS health staff need access to peer support and supervision, training, skills and career develop opportunities, cultural diversity training, and regular updates in clinical practice.	see page 211

Safety

25.	Provide more shaded areas to the yards in the SRC.	see page 214
26.	Review the terms of reference, including operation and membership, of the Use of Force Review Panel with the view to increase community input, including the Tasmanian Aboriginal community.	see page 215
27.	Provide, as a minimum, the Dedicated Response Team (DRT) and officers working with watch-house detainees with body cameras.	see page 216
28.	Obtain prisoner perspectives after every use of force so they can be fed back into the review of the incident.	see page 216
29.	Review the violence reduction strategies that are in use to ensure they are contemporary.	see page 217
30.	The State Government to consider how people on workers compensation can access the psychiatric care they require.	see page 218
31.	Consider how best to support people on workers compensation or sick leave, especially in light of the Wellbeing Officer role no longer being funded.	see page 219

Patient care and treatment

32.	Consider increasing nursing staff on duty in Hobart Reception Prison (HRP), as is done with correctional officers, during evenings and nights when there are public events likely to involve large crowds and substance use which may result in high numbers of arrests.	see page 220
33.	The medication management committee/ drugs and therapeutic committee should ensure all aspects of prescribing practice are in accordance with an established set of clinical guidelines for prescribing in correctional settings. Prescribing guidelines need to be developed where these differ from community treatment guidelines. A formulary needs to be agreed with clinicians.	see page 222
34.	All medication changes made at the point of admission (and thereafter) should be discussed with the patient before they are made. Until then drugs prescribed in the community should be continued unless contraindicated; wherever possible community health providers should be contacted for treatment information, and proposed changes discussed.	see page 224
35.	Electronic prescribing is established.	see page 225
36.	Historical paper medication charts should be moved and stored off site in a central location.	see page 225
37.	The policy and practice regarding drug availability in imprests in various sites should be reviewed and standardised and brought into accordance with Tasmanian pharmaceutical regulations. If pharmacy input is required at Launceston Reception Prison (LRP) this should be organised.	see page 227
38.	Commonly required medication should be available in imprests to avoid gaps in medication administration.	see page 227
39.	Evening medication rounds should be established particularly for sedating or psychotropic medication.	see page 228

40.	A multi-agency review of medication security should be undertaken with a view to enhancing it where possible, so reducing the potential for trafficking of medication and therefore increasing the use of medication that is therapeutically useful but deemed trafficable.	see page 229
41.	The use of on-person medication be reviewed.	see page 230
42.	Over the counter medication should be more readily available in the units. TPS and CPHS should work to establish an effective policy to implement this.	see page 230
43.	CPHS consider creating a list of medication that nurses across the prisons are permitted to dispense both with, and without, a prescription.	see page 230
44.	Medication be sent with prisoners to court with personal belongings as a matter of routine.	see page 232
45.	The post release medication practices should be reviewed and at least one week's medication should be sent with prisoners who are attending court or who are being released.	see page 232
46.	The criteria for access to dental care should be reviewed to include all patients, both sentenced and remandees, who meet the clinical criteria for care and they should be screened against these criteria by staff trained in dental triage.	see page 233
47.	CPHS should work with Oral Health Services to review and amalgamate the correctional and community waiting list to ensure people are not disadvantaged regarding their waiting times for dental treatment by virtue of changes to their custodial or legal status.	see page 234
48.	Dentistry services at the prison need to be doubled without delay.	see page 235
49.	CPHS to review input provided by allied health professionals and business cases prepared to increase input to meet demand where necessary.	see page 235
50.	Upgrade and mend the broken fittings in the Inpatients Unit.	see page 236
51.	Refurbish the areas of the old Inpatients Unit.	see page 236

52.	Review TPS and CPHS staffing of the Inpatients Unit, particularly the reallocation of TPS staff to other areas during lockdowns.	see page 237
53.	Review the use of the Inpatients Unit, the medical procedures that could and should be undertaken there, and deliver appropriate training to staff as soon as practicable to reduce the number of escorts to hospital.	see page 237
54.	Review the security needs of the Inpatients Unit to allow immediate medical access to all rooms.	see page 238
55.	Review the use, function and infrastructure of the Crisis Support Unit (CSU) to ensure it is a therapeutic space.	see page 239
56.	Increase number of medical escorts to hospital back to eight per day without delay. This will take some work regarding resourcing, but it should be a priority.	see page 239
57.	CPHS and TPS work with Royal Hobart Hospital (RHH) to plan the implementation of secure areas in the refurbished Emergency Department so they can be used by prisoners and escorting staff.	see page 240
58.	Develop a Memorandum of Understanding (MOU) with RHH and Launceston General Hospital (LGH) regarding mutual expectations and ways of working with prisoners to ensure their safety and welfare as well as that of the public. The MOU with RHH and LGH should also consider introducing regular visits of specialists to the prisons.	see page 241
59.	Review arrangements regarding escorts. Consider outsourcing of the transport function to an external provider while TPS is unable to staff the function to sufficient levels.	see page 241
60.	CPHS to liaise with TPS staff in good time regarding escorts required.	see page 242
61.	Increase use of video-conferencing and telehealth for healthcare, wherever possible, with outpatient clinics to minimise escorts required.	see page 242

Special needs and services

62.	Review the level of information and support required regarding the management of menopause and related symptoms.	see page 243
63.	Incorporate the Volunteers for Change program into the male estate and into the CPHS clinical governance program.	see page 243
64.	TPS reintroduce the peer support service into Mary Hutchinson Women's Prison (MHWP).	see page 244
65.	Develop Alcohol and Other Drug (AOD) rehabilitation services for women to reflect their level of need.	see page 244
66.	Mental health input to the MHWP may require review. An audit of need should be conducted and the input provided should reflect the level of assessed need.	see page 244
67.	AYDC engage an acoustic consultant to review the acoustic conditions in units and other areas, such as the gym, and implement the advice as appropriate to improve and create more calming acoustic conditions.	see page 246
68.	TPS and CPHS should conduct a recruitment drive targeted towards Aboriginal and Torres Strait Islander people.	see page 247
69.	CPHS should ensure that culturally appropriate care is provided to people from Aboriginal and Torres Strait Islander communities.	see page 247
70.	The need for transitional case management needs to be reviewed given the impact it can have on recidivism. Transitional case manager positions should be created and a manager appointed.	see page 248
71.	Assistance to those with disabilities to complete the requisite forms for services should be provided.	see page 250
72.	TPS and CPHS establish protocols to ensure prisoners have appropriate access to voluntary assisted dying.	see page 250
73.	Evaluation of the effectiveness of criminogenic programmes, especially in relation to substance use management, should be undertaken.	see page 252

74.	An alternative base for the Programs Team should be found so they are not accommodated in prison cells.	see page 252
75.	Criminogenic programs, especially those containing information about substance use management, should be reinstated within the prison service. They should be closely linked to community services, and ideally straddle delivery of program services in the community after the participant's release.	see page 253
76.	Criminogenic programs, especially those containing information about substance use management, should be available to women when required.	see page 253

Patients with alcohol and other drug problems

77.	Review the policy regarding supports provided for tobacco cessation to ensure the humane treatment of those dealing with nicotine addiction and withdrawal.	see page 256
78.	Improve conditions within the dry cell, which is used to house prisoners suspected of internally concealing contraband, including installation of a call button and increasing frequency of levels of observation.	see page 258
79.	Increase screening of staff, contractors and visitors on entry and at random (including drug testing).	see page 258
80.	Base AOD waiting lists on all those who require the service, not on legal status. Use this waiting list to assist making the case for development of AOD services.	see page 260
81.	Deliver AOD treatment to people who require it rather than limiting treatments to those for whom community services are being allocated.	see page 261
82.	Review policy and protocols regarding management of alcohol and drug withdrawal to ensure adequacy of care.	see page 263
83.	Include therapy as part of the opiate replacement program as per treatment guidelines.	see page 264
84.	Review criteria for placement on Opioid Replacement Therapy (ORT).	see page 265

85.	The leadership and structure of the delivery of AOD services is reviewed to ensure it is fit for purpose, contemporary and meets the needs of the prison population.	see page 266
86.	Parameters of eligibility for all AOD treatments and programs need to be created which reflect patient need. Criteria based purely on legal parameters (e.g. remand status) should be abolished. Waiting lists should be then used where necessary to demonstrate service insufficiency. Adequate support and clinical supervision for AOD staff, including off site support where required, should be structured into the program and fully funded to enable all treating staff to have sufficient access as part of the role. a. A space be identified for the delivery of a residential AOD therapeutic program pending the outcome of the business case for development of Division 8 in Ron Barwick Prison (RBP). Suitable prisoners should be identified for the program, moved to this area and the program initiated without delay. Whilst the program could be structured around the principles of Pathways, it needs multidisciplinary input and close integration with community AOD services, and with community services. Any carefully generated culture needs maintenance, or it can erode over time and this reduces program effectiveness. b. Custodial and therapeutic staff for this unit should be carefully selected. c. The effectiveness of the program should be evaluated.	see page 267
87.	Develop a business case for the establishment of an adequate number of AOD counsellor positions.	see page 268
88.	Introduce bleach needle-washing facilities and/or introduce needle exchange facilities.	see page 269
89.	AOD services deliver a range of education programs to CPHS staff and TPS staff regarding drug use in prison and treatment approaches	see page 270
90.	Develop a multi-agency interdisciplinary model of care for AOD service provision which extends into the community and uses the services of community providers who have contracts or Service Level Agreements (SLAs) to deliver coordinated services.	see page 271

Introduction

Inspectors

Mr Sam Christensen (Principal Inspection Officer)

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Sites visited

Risdon Men's Prison, incorporating:

- Risdon Prison Complex
  - Maximum
  - Medium
  - Southern Remand Centre
- Ron Barwick Prison

Mary Hutchinson Women's Prison

Launceston Reception Prison

Hobart Reception Prison

Ashley Youth Detention Centre

Acknowledgements

My thanks go to all those who made a contribution to the inspection, and who made me feel so welcome in all sites that we visited. This includes healthcare and correctional staff, prisoners, young people and others in the community. All spoke openly and frankly and shared their perspectives. I hope that some of these have found their way into these pages, and into these recommendations.

Personal reflection

The overwhelming majority of staff working in prisons and detention centre are dedicated hardworking and genuinely concerned for the welfare of people in their care. It is an extremely difficult environment in which to work, and it takes its toll on even the most robust individuals. I therefore enormously admire and respect everyone who chooses to work in these custodial centres. They need looking after too.

Standards

Custodial Inspector adult custodial centre physical healthcare standards[1]

75. The type of health care available to all prisoners should reflect the health needs of the prison population.

76. Informed consent must be obtained from a prisoner for all health care or for the sharing of personal information with others involved in the prisoner's care.

77. All prisoners should undergo a health examination by a qualified health professional within 24 hours after being received into prison.

78. Prison health services should be delivered in culturally appropriate ways.

79. All prisoners should have access to a 24-hour, on-call, or stand-by primary health service that is a registered doctor or nurse.

80. Prisons that hold female prisoners must ensure appropriate health care services are available to meet the particular health needs of female prisoners.

81. Every prisoner is to have access to the services of specialist medical practitioners as well as psychiatric, dental, optical and radiological diagnostic services, on medical referral.

82. Prisoners who are isolated for health reasons shall be afforded all the rights and privileges that are accorded to other prisoners, wherever practicable, and so long as such rights and privileges do not jeopardise the health of others.

83. There must be a safe procedure for the distribution of medications to prisoners.

84. Health promotion and education should be delivered in the language of choice of the recipient and in a culturally appropriate manner to the individual and the setting.

85. A health record file must be established for each prisoner at the first health assessment and all subsequent health contacts should be recorded in the file.

86. Health centre staff should be appropriately qualified.

87. Health Centre staff should be consulted on all areas of the prison regime relevant to prisoner health.

[1] Office of the Custodial Inspector Tasmania (2018)a

Management and treatment of substance misuse standards[2]

93. Prisons should have effective mechanisms to reduce the demand for drugs.

94. Prisons should have effective mechanisms to treat and reduce the harm caused by drug use.

95. Prisoners with alcohol misuse problems should have access to appropriate treatment and support.

96. All prisoners should be offered alcohol education programs to raise awareness of the potential harms and to encourage safe and responsible drinking based on informed choices.

97. In the interests of improved health, prisoners and staff are prohibited from smoking.

Method

Services were informed of the inspection in December 2022 according to Section 13 of the Custodial Inspector Act 2016 (the Act). Information was requested pursuant to s8(c) of the Act. Services were invited to submit written or verbal briefings. The inspection took place between 30 January and 10 February 2023. Health and correctional staff, prisoners and detainees from each site were interviewed, and peer groups consulted. Information about the inspection was provided on request. Facilities were visited and procedures observed. Initial impressions were provided. The draft report was submitted for comment before publication, and the response published with the report.

Context of prison health care

Services in prison

In broad terms health services in prison are provided not just to assess, diagnose, and treat physical health disorders, but also to rehabilitate, minimise impairment and disability and where possible prevent disorders from occurring, to minimise ill health and to optimise good health and wellbeing. There are three main strands of healthcare provided in prison: physical healthcare, which includes care provided within the prison and specialist care provided to people who are in prison, mental healthcare, and Alcohol and Other Drug (AOD) services for those with addictions. This inspection relates to the first and last of these. A Mental Health inspection was conducted during the course of 2022. There are a number of issues relevant to mental health, particularly in the context of comorbid disorders (that is to say mental

[2] Office of the Custodial Inspector Tasmania (2018)b

disorders where they occur in combination with substance misuse disorders which is the rule rather than the exception), which are raised in this report.

Community Services in demand

It is acknowledged that generally healthcare services within Tasmania are under stress, with demand outstripping supply across the health sector. Access to services in the community is becoming increasingly difficult. Overall, the service is inadequate to meet demand. Nowhere is this more evident than in the prison system.

Principles of prison healthcare

The National Statement of Principles for Forensic Mental Health[3] was endorsed by the Australian Health Ministers Advisory Council in 2006.[4] These principles apply to forensic patients within the forensic mental health system: this includes prisoners with mental illness requiring secure inpatient hospital treatment and those requiring specialist mental health assessment and/or treatment in prison.

> "The human rights abuses currently being committed against people affected by mental illness in remand and correctional facilities cannot be allowed to continue. Australia has undertaken to honour certain standards clearly set out in a range of international instruments — and these obligations must be honoured."[5]

These principles are so fundamental they apply equally well to all aspects of healthcare delivery. It was not anticipated that at the beginning of this inspection it would be necessary to revisit core principles underpinning the delivery of healthcare in prisons. However, during the course of the inspection it become apparent that a good number of these appear to be under considerable pressure in Tasmania.

These principles are well established internationally, and all apply at all times to everyone in prison or detention. Many relate to basic human rights obligations. They are not optional, to be wheeled out or remembered on a sunny day but need to underpin day to day operations and the ethos of the service. Alas at the current time in Tasmania in many instances this appears not to be the case. It may be because

[3] Australian Health Ministers' Advisory Council Mental Health Standing Committee (2006)
[4] These principles are underpinned by national and international policy frameworks, including: the UN Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care; The International Covenant on Civil and Political Rights; the Mental Health Statement of Rights and Responsibilities; the National Mental Health Strategy; and the Royal Commission into Aboriginal Deaths in Custody.
[5] Human Rights and Equal Opportunity Commission (1993)

there is no clear set of articulated principles underlying physical healthcare delivery in prison in Australia. There should be.

The basic medical principles are set by: The World Medical Association Declaration of Geneva (1948),[6] The International Code of Medical Ethics (2006),[7] The United Nations General Assembly resolution 37/194 (1982),[8] Recommendation No. R (98) 7 of the Committee of Ministers of the Council of Europe (1998)[9] on the ethical and organisational aspects of health care in prison.

The principles, which make up the core set for forensic mental health and are applicable to physical health care delivery, are worth exploring in detail.

Equivalence to the non-offender

The role of imprisonment is the deprivation of liberty. It is not the function of prison authorities to impose additional deprivations on those in its care,[10] whatever the nature of their offence. Those who are imprisoned retain their fundamental right to have the highest attainable standard of physical and mental health.[11] It is incumbent on a system that deprives someone of their liberty to ensure adequate medical care is provided, and to promote physical and mental wellbeing.

There is international agreement relating to the principle of equivalence. The World Health Organisation strongly advocates for healthcare delivery to be based on the principle of equivalence, where the nature and quality of services are the same as provided in the community.[12] The Committee of Ministers for the Council of Europe (1998) stated that respect for fundamental rights of prisoners entails the provision to prisoners of preventative treatment and health care equivalent to those provided to the community in general.[13]

The Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[14] states:

> "Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease to the same quality and standards as is afforded to those who are not imprisoned or detained."

[6] World Medical Association (1948)
[7] World Medical Association (2006)
[8] United Nations (1982)
[9] Council of Europe Committee of Ministers (1998)
[10] Coyle (2009)
[11] United Nations (1966)b
[12] World Health Organisation (2007)
[13] Council of Europe Committee of Ministers (1998)
[14] United Nations (1982)

Prisoners in Tasmania therefore have the same rights to availability, access and quality of health care as the general population. This means access to modern equipment, adequately trained staff, access to medical facilities and to hospital-based care where this is needed. Equality is needed irrespective of the individual's status, gender, sex, age, culture, sexual orientation, religion, nationality, health status, level of disability, or need, or whether primary or secondary specialist care is required.

Due to many significant social and economic factors, the health of prisoners is often poor when compared to people in the community: there is a high rate of physical and mental illness in prison, and a high rate of substance misuse problems and intellectual and physical disability. Many people in prison do not have ready access to medical services when they are in the community. Therefore, when they come into contact with the correctional system, they often have greater levels of need than average within populations and these need to be taken into account when services and resources are allocated. Service delivery in prison should not be limited by services available in the community: that is to say that if services available in the community are poor for whatever reason, this does not provide an excuse for similar poor service delivery in prison.

There are also a number of vulnerable populations in prison, including high rates of Aboriginal and Torres Strait Islander people, people from culturally linguistically diverse backgrounds, and juveniles. They often require enhanced access to medical services greater than that provided in the community to meet enhanced levels of need.

There were many examples found within this inspection, which are detailed in this report, where healthcare delivery was not of an equivalent standard to that provided in the community. Access to general healthcare, specialist hospital care and dental care are three obvious examples.

Safe and secure treatment

Treatment and care will be delivered in an appropriate environment compatible with treatment and rehabilitation needs of the individual and the community's need for safety.

People in custody or detention should not be harmed. A substantial part of the work of health services in custody is dealing with injuries sustained during the course of imprisonment. This includes injuries from violence, self-harm, and sometimes the physical consequences of the use of force by correctional staff. Clearly there is a legitimate need to protect people from and prevent dangerous or disruptive behaviour. There is also a need to protect vulnerable individuals from risks within the prison environment. But it follows that no custodial practices such as use of force, restraint, or segregation should cause harm. Wherever possible prisons should

promote wellbeing. Environments which provoke ill-health are inappropriate. In addition, the environment in which healthcare is delivered needs to be therapeutic.

Within the prison several therapeutic environments are offered which are distinctly nontherapeutic (the Crisis Support Unit (CSU) and the old part of the Inpatients Unit for example). Use of force also causes harm. Nowhere is the harm more profound, however, than the widespread use of segregation of prisoners when the prison is short of staff.

Responsibilities of health, justice and correctional systems

The provision of healthcare for offenders is a joint responsibility of Health, Justice and Correctional systems and must be addressed in partnership. Each has their own responsibilities, and to be effective contributors need cooperation, communication, agreement and planning. Health services are usually operated by health providers rather than correctional staff, but they cannot undertake their role without correctional support. Many health interventions cannot be undertaken within correctional establishments as access to medical facilities and procedures requiring hospital-based care is needed. The health needs of prisoners and detainees need to be determined by health staff, and correctional services are required to determine that the individual's safety and security needs are met. It should not be for correctional staff without medical training to determine the health needs of prisoners.

The single mission of health staff must be to care for patients' health. Complete professional independence is essential: in order to guarantee this, personnel should be aligned as much as possible with mainstream healthcare provision[15] (while remaining in effective liaison with prison management).

Health care in prisons is often not seen as a core service role of corrections staff or facilities, which is the punitive containment of prisoners for as long as the courts determine. There is a risk that healthcare can be treated as an inconvenience. The above principles are needed to ensure that healthcare delivery is not seen as optional, only to be provided when the prison is able to do so, or at the whim of the provider of custodial services or responsible governmental department. The partnership between health and correctional services needs to be a proper working partnership that extends throughout the organisation, from government departments, through to senior management of health and corrections, to the units and cells and healthcare centres where the healthcare is provided. Where there is a power imbalance, healthcare delivery is jeopardised, the health of prisoners deteriorates, morale falls, healthcare staff are at risk of being bullied into following correctional agendas rather than health agendas, and relationships are at risk of deteriorating.

This process is occurring in some of the adult prisons in Tasmania.

[15] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1992)

Access and early intervention

"Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation"[16]

A prisoner should have timely referral and access to specialist health services when appropriate. The range of treatments and interventions and qualifications of staff should be the same as that in the community. All who need access to medical care should receive it. This includes timely access to primary and secondary care when medically appropriate. It includes access to a trained clinician who is able to meet their needs. Anyone arriving in custody should have their needs assessed and acted upon appropriately. All prisoners should have access to facilities within the custodial setting where their primary healthcare needs can be met. There should be the same access to treatments and interventions, rehabilitation, physical and mental health and drug and alcohol treatments as available in the community. There should be access to referrals to specialist care where required. The same range of medical services should be available as to the general community: people's access to health services should not be disadvantaged due to their status as a prisoner or detainee.

The Human Rights Handbook for prison staff[17] states:

"Prison administrations will need to ensure that they make suitable arrangements which are based on the needs of prisoners and that the required treatment is not restricted on the grounds that it is deemed to be too expensive merely because the patient is a prisoner."

Day to day in Tasmania, multiple reasons can be found as to why access to healthcare may not be achieved. All these threaten this principle to such an extent that lack of access can be commonplace, and the principle quite simply forgotten.

Comprehensive services

This consists of inpatient services, prison health services, courts and community based services working in a coordinated clinical and administrative stream. Services should be evidenced based, multidisciplinary, and continuous, with exchange of information, and participation by all agencies in case management.

The vast majority of prisoners are visitors: in general, they are community members obtaining services in the community, who come to prison on a temporary basis only:

[16] UN (1990)
[17] Coyle (2009)

most return to the community from whence they came. They bring their healthcare needs with them and take them when they leave. To deliver appropriate care it is necessary to understand the health and psychosocial context from which they come and the context to which they will go, to ensure ongoing conditions are managed and their health maintained.

There are often different governance arrangements for different parts of the system in Tasmanian adult custodial centres, working in silos with poor transfer of information between each. Many services are not multidisciplinary or multiagency. There are few care plans and little case management. This means that comprehensive services in Tasmania are often aspirational, rather than considered as a core principle or mandated requirement.

Integration and linkages

Integration of elements within health systems is required to minimise barriers to treatment within the most appropriate setting, requiring a coordinated and integrated approach.

Services need to be provided which straddle various barriers including health-custodial services, prison health and community health, and which involve many health and other human services agencies. There are often cultural differences and differences in overall approach, attitude, expectations and priorities which need to be negotiated. This can be no easy task and requires flexibility, understanding, and different perspectives. In stressful or high-pressure situations, these are often the first things to go. This is why standards of care are so often required, and why these need constant attention if standards are not to be gradually eroded.

Services should provide multidisciplinary, evidence based, continuous and managed care. Care should include:

- prevention;
- rapid, comprehensive and thorough assessment;
- treatment planning;
- treatment;
- rehabilitation;
- care coordination;
- handover of care;
- pre-release planning;
- transitional and discharge care;
- linking with other agencies;
- culturally sensitive care; and
- facilitation of diversion to appropriate treatment settings.

This can be particularly challenging for people from the homeless community, those who use substances or those who are violent and aggressive. If health services

within the Tasmanian adult prisons self-assess against this list, it appears to tick few of these boxes.

Ethical standards

Rights to respect for human worth, dignity, privacy, confidentiality, rights to consent and all other civil and human rights and freedom from abuse must be upheld and protected and not eroded by any circumstance or opinion. Information sharing should be limited to that necessary for provision of treatment and care. Health records should be kept separate to correctional records and not accessed by correctional staff. The right to give fully informed consent (or not) should be upheld: it should not be forfeited by status or offence, only by capacity, and then with the appropriate safeguards and legally mandated substitute decision making measures in place. Civil and human rights should always be upheld, and this includes freedom from all forms of abuse.

For the majority of prisoners for the majority of the time, these standards are upheld.

Staff knowledge attitudes and skills

Rule 49(1) of the 1955 Standard Minimum Rules for the Treatment of Prisoners[18] states:

> "So far as possible, the personnel shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers and trade instructors."

To maintain high degrees of professionalism and strong clinical leadership, appropriate training and support are required to maintain a highly skilled workforce. Appropriate levels of supervision, support and safety must be available.

Prison health staff are susceptible to relentless and excessive demand, professional isolation, burnout, care fatigue (in which the health culture of care is gradually replaced by a set of custodial cultural attitudes), and the effects of challenging circumstances in unfavourable working environments. To prevent this and maintain a professional and skilled workforce fit to maintain high quality care provision, all health staff need access to peer support and supervision, training, skills and career develop opportunities, cultural diversity training, and regular updates in clinical practice.

All these require review.

[18] United Nations (1955)

Individualised care

The 1955 Standard Minimum Rules for the Treatment of Prisoners,[19] Rule 62 states:

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

Prison mental health services must meet the changing needs of an individual, and take into account their biological, psychological, social, cultural and spiritual context. This implies regular review, and involves significant others and other agencies in treatment, support and care.

The provision of individualised care in an environment which routinely results in the stripping away of individual autonomy, identity and needs as part of a normalised prison regime is challenging. Within the prison context prisoners are required to conform to the needs of the regime which almost always comes first. Within the health context, needs of the individual are paramount and dictate the response required. This care needs to take into account the entire person: their biological, social, psychological, cultural, familial and spiritual context, particularly those with specific or unusual needs.

It is a constant struggle to provide individualised care in prison contexts, and constant vigilance is required to ensure individual care needs are not ignored in favour of the needs of the institution. This is happening on a daily basis with recurrent lockdowns.

Quality and effectiveness

There must be a quality improvement process (and this must include carers and consumers) to improve performance outcomes and which includes actions to address identified deficiencies. Quality care and containment must be provided in a cost effective and efficient manner. This is the basis of clinical governance. Inspections such as this should be seen as part of a quality and improvement process, but there also needs to be an internally driven culture of continuous improvement in delivering services and constantly striving for improvement, an awareness and lack of acceptance of known shortcomings. The improvement of health services should be data and target driven. There needs to be an established clinical governance program. This appears to be lacking.

[19] United Nations (1955)

Transparency and accountability

Services must be subject to accreditation against national standards for mainstream services, with external and peer review. Idiosyncratic practices and standards inevitably creep into isolated services, and services should be regularly externally accredited to ensure this cannot happen. Services also need internal and external review, particularly after untoward events. Health services within prisons should be benchmarked against other prison and non-prison services. There should be access to complaints mechanisms such as the Ombudsman and Health Complaints Commissioner. There should be community visitors and external scrutiny.

Judicial determination of detention and release

This applies to some people with mental illness who are on forensic orders by virtue of mental disorder. Decisions regarding detention, release or transfer should be made by courts or independent statutory bodies and not by the political process or the Governor. This principle does not apply to this health inspection.

Legal reform

Legislation must recognise the special needs of people within the criminal justice system and comply with the International Covenant on Civil and Political Rights,[20] and the UN Principles on the Protection of People with Mental Illness and the Improvement of Mental Health Care.[21] This mostly relates to those with mental health disorders and is included here for completeness.

Healthcare in Prisons in Tasmania

Principles and standards of health services in prison have been widely debated and are now broadly internationally accepted. They come from a number of nationally and internationally recognised bodies.

Blindly meeting targets of efficiency levels or working to budgetary constraints in prison without considering ethical consequences can lead to inhumanity. In failing to meet the health needs of people with disorders in the criminal justice system in Tasmania, human rights are not sufficiently respected. Despite being signatory to both the Universal Declaration of Human Rights[22] and the United Nations Convention on the Rights of Persons with Disabilities,[23] within prisons in Tasmania and the rest of Australia these rights are regularly being breached. These rights need to be taken seriously and upheld.[24] In Australia minimum standards for healthcare

[20] United Nations (1966)a
[21] United Nations (1991)
[22] United Nations (1948)
[23] United Nations (2006)
[24] National Mental Health Commission (2013)

provision to prisoners are rarely formally set or monitored[25] except by custodial inspectorates.

Prisoners have a right to health[26,27] which must have these qualities: availability, accessibility, acceptability and quality of facilities, services and goods. There is an enforceable duty of care. In Europe this duty applies even in times of fiscal austerity, and lack of financial means cannot reduce this responsibility.[28] Dual loyalty (where duty to care for sick prisoners may enter into conflict with considerations of prison management and security) poses an ethical dilemma for prison healthcare staff.[29] For example, medical decisions can be overruled by non-health staff. Prison budgets, policy and management can restrict health staff from exercising clinical judgement. This can herald a gradual erosion of duty of care which must be fearlessly guarded against.

The Council of Europe (2014)[30] published a manual on prison healthcare and medical ethics. It provides practical information for those with the responsibility for prisoners' healthcare, particularly ethical issues relating to access to a doctor, equivalence of care, consent issues, confidentiality, preventative healthcare, humanitarian assistance, professional independence and competence. It is worth a read.

Overall Impression

The partnership between health and correctional services needed to ensure delivery of high quality healthcare to prisoners and detainees is at risk. It is eroded by the inability of TPS to facilitate access to health services that are available, both in prisons and in local hospitals. This is having a very grave effect. It is essentially preventing the health service from undertaking its duty. The professionalism and effort of staff is undermined, it impairs teamwork, relationships, trust, morale and provokes complacency. This is undermining many of the principles upon which the service is built.

Recommendation 1

Tasmania Prison Service and Correctional Primary Health Services develop a set of principles for the delivery of healthcare services and monitor their services against these principles.

[25] Dean et. al. (2013)
[26] World Health Organisation (2013)
[27] United Nations (1966)b,
[28] Council of Europe (2020)
[29] Pont (2006; 2012)
[30] Lehtmets (2014)

Access to care

Introduction

During the inspection between 29 January and 10 February 2023, the number of prisoners in Tasmania was about 690. According to Australian Bureau of Statistics data as of 30 June 2014 there were 448 prisoners in Tasmania.[31] It was evident that during these nine years in which the numbers of prisoners increased by 54%, the physical capacity of the correctional system had to increase to accommodate them. In some cases, prisoners have had to share cells, but most importantly a new unit has opened: the Southern Remand Centre. This can house up to 156 remandees and has significantly addressed overcrowding issues.

Across the prison estate and in every area of activity, during this inspection we heard about a significant and ongoing shortage of staff, and an inability to operate the prison as required. Whilst this has affected both non-uniformed and uniformed staff, whose numbers have not increased by 54%, the current shortfall appeared to be most significant in the numbers of uniformed staff available to undertake day to day duties.

This has a major effect on the general operating of the prison, but in particular on access to care and hence the health of prisoners. The ongoing and repeated cancellation of health clinics, appointments and escorts to hospital is so significant that it breaches prisoners' rights to access care (as described above) when they need it.

Effect on the prison

When daily shortages of staff are known, decisions have to be reached about how best to deploy the staff who are available, across all the areas in the different prisons which require staffing. Of course, this varies according to the security rating and type of prison or function of the unit. In addition, staffing has to remain somewhat flexible to account for day-to-day differences in acuity, prisoner numbers, security requirements, activities and needs.

The position in February 2023 was that once as many as 14 or more staff are absent during the day shift in RPC, this prison would be in a state of lockdown. It is understood that this number has been previously agreed with the United Worker's Union and the Community and Public Sector Union (hereafter referred to as the unions). It reflected an agreement between the then senior management team and the unions about levels of staff required to manage the prison in a safe way, the primary concern being the maintenance of safety and security within the prison.

[31] Australian Bureau of Statistics (2014)

Lockdowns

When insufficient staff arrive for work, the staff that are available are distributed to optimise safety, functioning and activity. If there are not enough staff in some areas, restrictions are placed on what prisoners can do and the activities that can take place. In normal circumstances when sufficient staff are available, prisoners in those areas are let out of their cells into the unit so they can associate, and the units can be opened so they can go outside and take exercise in the yard. Prisoners can attend other areas of the prison for visits, medical appointments in the Health Centre or be escorted to the RHH, for therapy, education, or undertake their jobs. In essence the prison can function normally.

When there are insufficient staff available to facilitate these activities, they may be curtailed to a greater or lesser degree. Usually only some of these activities stop, in some areas, or stop for part of a day, but in extreme cases prisoners are kept in the cells, locked down all day, without any of these activities occurring. This can occur for several days in a row. This is happening increasing frequently.

Numbers

During the period of the inspection, 30 January - 10 February 2023, between a third and a half of the units in the RPC (including the SRC) were in lockdown. This was similar to previous months.

The number of full, half, and part day lockdowns that occurred in January 2023 across TPS facilities is presented in the table below. The table clearly demonstrates that the maximum and medium security precincts within the RPC and SRC are the worst affected by lockdowns, with the maximum security precinct most adversely impacted.

Since January 2020 the trend for lockdowns has gradually increased. It is not a new problem.

Lockdowns also occur at RPC almost every Wednesday throughout the prison for training purposes.

Recommendation 2

If prison lockdowns are urgently required for regular training, they occur a maximum of one day per month.

Tasmania Prison Service Lockdowns - January 2023

	Lockdown type			Total lockdowns
	Full day	Half day	Part day	
Risdon Prison Complex - maximum security precinct				
Apsley	13	14	3	30
CSU	7	12	11	30
Derwent A	11	9	3	23
Derwent B	10	10	3	23
Inpatients	12	8	11	31
Mersey	7	12	11	30
*Behavioural Management Units**				
Franklin	19			
Tamar	16			
Huon	12			
Risdon Prison Complex - medium security precinct				
Basic Regime	10	0	0	10
Mainstream Regime	9	6	9	24
Southern Remand Centre				
Acacia	8	6	7	21
Blue Gum	9	5	7	21
Ron Barwick Prison				
Divisions 1-7	0	0	0	0
O'Hara Units	0	0	0	0
Mary Hutchinson Women's Prison				
Wellington (Maximum Security)	0	2	5	7
Hartz – High (Medium Security)	1	0	4	5
Hartz - Medium (Medium Security)	1	0	4	5
Vanessa Goodwin Units (Minimum Security)	0	0	3	1
Reception Prisons				
Hobart Reception Prison	0	0	3	3
Launceston Reception Prison	0	0	0	0

* Only full day lockdowns have been reported for these behavioural management units due to the use of walk groups.
The definition of a full day, half day, and part day lockdown varies by unit / facility. These are defined below:

Unit / Facility	Length of lockdown (hours)		
	Full day	Half day	Part day
Risdon Prison Complex Maximum Security Precinct	≥8.25	≥4.0	<4.0
Risdon Prison Complex Medium Security Precinct Basic Regime	≥1.0	≥0.5	<0.5
Risdon Prison Complex Medium Security Precinct Mainstream Regime	≥8.25	≥4.0	<4.0
Southern Remand Centre	≥9.0	≥4.5	<4.5
Ron Barwick Prison	≥15.5	≥7.5	<7.5
Mary Hutchinson Women's Prison Wellington	≥9.25	≥4.5	<4.5
Mary Hutchinson Women's Prison Hartz (High and Medium)	≥10.0	≥5.0	<5.0
Mary Hutchinson Women's Prison Vanessa Goodwin Units	≥11.0	≥5.5	<5.5
Hobart Reception Prison	≥9.5	≥5.0	<5.0
Launceston Reception Prison	≥8.5	≥4.0	<4.0

Effect on prisoners (and staff)

Prisoners do not know when lockdowns will occur. In at least some units they are usually informed at 8:00 am via loudspeaker if they will need to remain isolated within their cell for all or part of their day, and whether any planned activities will be occurring. We heard from prisoners variously that this creates:

- uncertainty;
- mistrust;
- a degree of paranoia;
- a sense of unfairness;
- resentment;
- frustration;
- anger;
- disappointment;
- loneliness; and
- boredom.

It also stimulates unrest. When prisoners are eventually let out of their cells, perhaps after several days of confinement, they are overstimulated, and these resentments often spill over into confrontation with one another, or with staff.

This often makes the days immediately following lockdown high stress days for both prisoners and staff. There is catch-up from delayed activities, but the expressed emotion from everyone is often significant. We were informed that some staff respond to the prospect of a difficult day ahead after a lockdown by avoidance, and do not attend work, and this can have the effect of further reducing staff numbers, prolonging the lockdown or curtailment in prison functioning.

Segregation

It is known that prolonged separation from others (also termed segregation in custodial settings, or seclusion in mental health settings) is inherently unpleasant. Solitary confinement has been used for centuries as an additional punishment for misdemeanours within prison, or has been used by courts in times past or in certain jurisdictions today to increase the punitive aspects of the sentence. In extreme circumstances it has been used as a form of torture.

In mental health settings seclusion is termed a restrictive practice, used not punitively but as a measure of last resort to maintain safety, and in many jurisdictions its use has been banned, minimised, or is being significantly reduced such are its harmful effects. Although safe cells or observation cells are used in prison to observe acutely ‘at risk’ people, they are deemed counter-therapeutic, and are also in essence a form of segregation. Prolonged isolation does occur when someone is in a safe cell, which can be for up to 23 hours per day. Usually, the only human

contacts are not chosen by the person, are monotonous and they may not always be empathetic. It is recognised that such segregation can sometimes be used as a substitute for proper medical or psychiatric care for mentally disordered people in prison.

Some members of the SMT and other senior uniformed staff were therefore understandably concerned about the potential use of the term segregation to describe what was occurring to prisoners during periods of lockdowns. They stated that segregation in TPS required a specific order, it occurred in a specific space designated for the purpose (i.e., not their own cells), without access to belongings or a phone. They argued that it applied according to certain rules, was a consequence of certain events, the prisoner was aware of what was going to happen or in many circumstances how long the segregation was to last. During segregation the prisoner is allowed out of their cell for a short period (usually an hour) for exercise and or fresh air. It was therefore argued that what happened in lockdown was quite different to segregation and the two could not be equated.

Their arguments were not at all convincing. Segregation is internationally defined as cellular confinement and isolation for 22 to 24 hours per day.[32] In many ways what happens in maximum and SRC lockdown is worse than what happens during segregation:

- it does not happen with warning;
- it is completely unexpected;
- it does not happen as a consequence of misbehaviour (and is therefore completely out of the control of the prisoner);
- it is often not possible to let prisoners outside at all during the day;
- they do not know how long it will last; and
- many planned activities (such as planned medical appointments) have to be cancelled.

Therefore, for the purposes of this report, the confinement of prisoners to their cells due to lockdowns constitutes segregation.

Recommendation 3

During prison lockdowns, each prisoner who is confined to their cell is considered to be in a state of segregation.

[32] The Istanbul Statement on the Use and Effects of Solitary Confinement (2008)

The use of lockdowns should not be seen as routine. But at RPC it has been happening so frequently that many staff now think of it as routine, and many are not dismayed or surprised by it. It seems that the adverse effects of it on prisoners are often not fully appreciated, or can be overlooked.

Recommendation 4

Prisoners in segregation have at least one hour out of their cell every day in line with the Corrections Act 1997 and international humanitarian obligations.

Effect of segregation on health

As a general principle the prisoner is to be placed in the least restrictive accommodation that maximizes the prisoner's safety. This is because solitary confinement is prejudicial to the mental health of the prisoner[33]. In WA, this was recognised as far back as 1861 by the Chief Medical Officer at the Fremantle Convict Establishment:[34]

"From a medical point of view I think there can be no question but that separate or solitary confinement acts injuriously, from first to last, on the health and constitution of anybody subjected to it ... the symptoms of its pernicious constitutional influence being consecutively pallor, depression, debility, infirmity of intellect, and bodily decay."

More recently, the 2007 Istanbul Statement on the use and effects of solitary confinement[35] stated:

"It has been convincingly documented on numerous occasions that solitary confinement may cause serious psychological and sometimes physiological ill effects. Research suggests that between one third and as many as 90 per cent of prisoners experience adverse symptoms in solitary confinement. A long list of symptoms ranging from insomnia and confusion to hallucinations and psychosis has been documented. Negative health effects can occur after only a few days in solitary confinement, and the health risks rise with each additional day spent in such conditions."

[33] Coyle (2009); Smith (2006); Haney (2003); Grassian (1983)
[34] Attfield 1861
[35] The Istanbul Statement on the Use and Effects of Solitary Confinement (2008)

Segregation is not an appropriate punishment other than in the most exceptional circumstances.[36] In all cases where prisoners are held in solitary confinement, each prisoner should be monitored on a daily basis by a doctor to note any deterioration in their health, and in that case the 'punishment' should be ended. Such punishment harms prisoners who are not mentally ill and worsens the condition of those who are. It should be prohibited for mentally ill prisoners.

Recommendation 5

People who are mentally ill are not subject to segregation unless it is by a specific order, such as disciplinary segregation or medical segregation.

The European Prison Rules[37] 43.2 and 43.3 provide:

"The medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to the health of prisoners held under conditions of solitary confinement, shall visit such prisoners daily, and shall provide them with prompt medical assistance and treatment at the request of such prisoners or the prison staff."

"The medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being put seriously 'at risk' by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement."

If segregation is used, the impact on mental health can be minimised.[38] Possible interventions include:

- raising the level of staff-prisoner contact;
- allowing access to social activities with other prisoners;
- allowing visits;
- arranging in depth talks with psychologists, psychiatrists, religious prison personnel, or volunteers from the local community.

[36] United Nations (1990)
[37] Council of Europe (2006)
[38] The Istanbul Statement on the Use and Effects of Solitary Confinement (2008)

There must be meaningful in-cell and out-of-cell activities.

The reason for stating this so clearly is that there is a very real danger in keeping someone in segregation. The internationally accepted rules regarding the medical management of people in segregation are also clear.

Recommendation 6

People in segregation should be medically reviewed according to international guidelines.

Effect of lockdowns on access to healthcare

When lockdowns occur there is a knock on effect on many other activities within the prison, not least healthcare. During January 2023 the Inpatients Unit itself was locked down for 12 full days, and for an additional eight half days, and the outpatients unit closed for ten full days and 12 half days.

When this occurs, correctional staff are not able to facilitate prisoners' attendance at the healthcare centre. Most appointments are cancelled. It is rare that practitioners attend units to see patients on the unit. Most are not permitted to walk between units unaccompanied, and staff are unavailable to facilitate this either. In addition, it is common that external escorts to hospitals are also cancelled. If the prison cannot open due to inadequate staff numbers, it is likely there will be insufficient staff to permit escorts to hospital to occur. In emergency circumstances escorts are found, so it is routine appointments which tend to get cancelled.

Recommendation 7

Correctional Primary Health Services staff receive the appropriate training to be permitted to walk within the maximum and medium security parts of the prisons unaccompanied.

In some parts of the prison (especially maximum security where most lockdowns occur) it routinely takes a month for a prisoner to be seen by the prison GP. Access

in other prisons such as the MHWP or RBP where lockdowns occur much less regularly if at all, access is relatively very good, in some cases as good as in the community.

Recommendation 8

Correctional Primary Health Services ensure appropriate standards relating to waiting times to see doctors are set and audited in a rolling cycle.

Data regarding cancellations of medical appointments in 2022 and the reasons for them was provided after the inspection. There were multiple different categories that could be selected for the reason for cancellations, and it seemed manual manipulation was necessary to prepare the data the inspection team received. A new operating system is soon to come into effect, however, which should hopefully improve the accuracy of the data.

In terms of medical appointments, we were advised that a total of 14,551 medical appointments occurred for the whole of CPHS in 2022. The number of medical appointments, on top of that figure, that were cancelled is as follows:

- Number of cancelled dental appointments: 161
- Number of cancelled medical appointments: 10,371
- Number of cancelled medical escorts: 663

The low number of dental cancellations is positive and is likely a consequence of a dental suite now being available in Ron Barwick Prison. Previously there was only one in RPC. The dentist is scheduled to go to Ron Barwick once a fortnight and RPC once a fortnight. When RPC is locked down and escorts to the dental suite are not available, the dentist is now able to attend Ron Barwick instead. Only six (3.7%) dental appointment cancellations were attributed to TPS staffing, the majority were due to ‘prisoner discharged’ (53.4%), so where a prisoner is released from custody prior to their appointment, or ‘duplicate appointment’ (22.4%).

At least 29% of the cancelled medical appointments were due to TPS staffing but we were advised that other categories, including ‘unavailable other’ (3.7%) and ‘not appropriately categorised’ (20%) could also include some cancellations relating to prisoner access. Regardless, TPS staffing was the most significant reason for medical appointments being cancelled, followed by ‘not appropriately categorised’, ‘prisoner discharged’ (11.8%) and ‘CPHS staffing’ (10.9%).

TPS transport/staffing was recorded as the reason for 37.9% of cancelled medical escorts. Again, we were advised that other categories such as ‘Hospital rebooked’ (5.1%) and ‘Other reason’ (23.7%) are often related to TPS transport issues. After TPS staffing and ‘Other reason’ the other major categories included ‘prisoner discharged’ (16.4%) and ‘prisoner refused to attend’ (10.9%).

The number of medical escorts that can be facilitated by prison staff each day has fallen significantly over the last six months or so, falling from eight per day to two to three per day. This includes health escorts of any kind, whether routine or emergency, so if an unexpected medical event occurs, which does appear to happen regularly, routine appointments are regularly cancelled. Due to the lengthy public hospital waiting times for these appointments, many prisoners have been waiting for these consultations often for many months if not years, and to have them cancelled on the day without warning is often a huge disappointment. It can be several months before these appointments can be rescheduled, and this prolongs suffering and delays treatment. Subsequent cancellations and delays may also occur.

The access to medical dental and mental health services has been significantly impaired and is now inadequate. This is widely acknowledged by prisoners, CPHS staff, TPS staff and specialists. The stated reason is lack of staff. As demonstrated above, lockdowns are frequent and occur on successive days, sometimes four at a time.

The view of health staff is that some patients have different perspectives from them regarding what constitutes a medical desire and what is a medical necessity, and so patients may issue complaints about lack of access to services when in fact they do not require a medical service. However, this explanation of the increasing numbers of prisoners requesting services accounts for only a small proportion of the increase: by far the larger arises from people not having their needs met. Routinely health requests to see the nurse or doctor take two weeks to get any response, sometimes longer. Access to some services such as dentistry is rationed: it is denied altogether if the patient has been in prison for less than six months when the request is made or if they are on remand (see below). The rationale (apart from obvious rationing) was not made clear. The idea of any access to allied health professions was met by prisoners in a peer group with derision and laughter.

The effect of lockdowns on the delivery of prison healthcare is significant because it effectively denies prisoners the access to healthcare that they are entitled to.

Causes of lockdowns

Senior Management Team explanations

The Senior Management Team gave a number of explanations for the shortage of staff causing lockdowns. Given the impact on healthcare delivery, these are worth exploring:

The prison has expanded but the staff base has not matched the increase

This explanation has some merit. A business case was submitted to increase the number of staff to run the new Southern Remand Centre before it opened, but this was not successful in full. No explanation regarding why was provided. Feedback regarding the business case was not shared, so it is not clear whether the case was inadequate, it was too expensive, or simply unjustified. It seems bizarre that a whole new remand centre can be financed, planned and built, and then opened with inadequate staff positions to run it. The consequences are utterly foreseeable, and have been realised. It is not clear whether the business case for the unfunded positions has ever been resubmitted, and if not, why not. Nevertheless, as a consequence, the new areas have had to be staffed with a limited staff compliment. It is clear that the Department of Justice needs to request an updated business case for the proper staffing of this new unit and reconsider approving it in the light of the consequences of not doing so.

Recommendation 9

The business case for expansion of the available staff base with the opening of the Southern Remand Centre is reviewed and resubmitted.

Workers compensation

The numbers of staff on workers compensation appears to have remained steady, but is extremely high. Sixty people (more than 10% of the entire corrective work force) are deemed to be permanently disabled. This is explored below and is a cause of considerable concern, as it reflects multiple issues. Of greater concern is that this does not appear to be a new problem, and little appears to have been done to consider how to reduce it. This is likely to be an issue which will remain for some time, and therefore further consideration should be given to how to address it. It would help if this cohort of permanently unavailable staff were not considered as part

of the workforce which is available for work, and therefore part of the staff base. If they were removed from the staff base, then those positions could be refilled with people who are available for work. Of course, the funding of those on workers compensation would need to be maintained and would need to be considered as an additional cost.

Recommendation 10

Staff on workers compensation considered to be permanently incapacitated should be removed from the Tasmania Prison Service staffing establishment to enable recruitment into their vacant full time equivalents.

It is a school holiday

The presumed explanation for this as a potential cause is that during school holidays staff who are parents need to look after their children whilst they are away from school, or they may go on a family vacation. This appears to be a short term explanation for a long term issue.

Recruitment

A recent recruitment round was cancelled for lack of applicants. The explanation given for this is the competition between industries for workers. There is particular competition with the police force, and their terms and conditions are deemed more attractive to aspiring workers. Public sector workers in Tasmania were described as being paid less than workers at a similar level in other states and territories, and so attracting interest from potential staff from other states can be problematic. This probably needs to be considered at a state-wide level. The possibility that TPS may not have a good reputation as an employer of choice within Tasmania did not appear to have been considered.

The union position on safe staffing levels

According to the SMT, the unions had not changed their views on the safe level of staffing required before prisoners should be unlocked. The SMT was of the view that unlocking of prisoners could safely occur with fewer staff present than are currently required, and so this could reduce the number of lockdowns which follow. This is clearly a highly sensitive industrial issue relating to staff health and safety. We are aware that negotiations relating to this matter are ongoing. We encourage both

parties to reach an agreement on this issue as soon as possible for the benefit of the health of prisoners.

Recommendation 11

Tasmania Prison Service and the unions are both encouraged to reach agreement about staff numbers required to fully operate the prison and the threshold for when lockdowns are required on the basis of staff shortages.

Other possible causes which were not raised by the Senior Management Team

Work culture

It is well established in any industry that staff absenteeism can be a reflection of prevailing workplace culture. The culture in Tasmanian Prisons is likely similar to that in prisons in most other jurisdictions.

At the top of their formal briefing to the inspection team the SMT were extremely proud to inform us that their style of management was 'command and control'. In general, this means maintaining a very hierarchical structure, akin to those found in the armed forces, police and other uniformed services. The implications of this are worth exploring, not least because multiple examples of this 'command and control' management style and workplace culture were indeed evident throughout all levels of the organisation. This has significant implications for the organisation, and in part underpins the current staffing crisis which is having such a profound impact on physical healthcare. The most worrying aspect of this was that the link between this culture and the staffing issues appeared to have been completely lost on the SMT.

The 'command and control structure' and culture which was proudly boasted of by the SMT is a relic of past business practices. 'Command and control' generally means the exercise of authority, responsibility, policy and procedures, decision making and leadership using a top down approach or chain of command, vesting power in senior management. By definition it is inflexible. The 'command and control' management style usually requires immediate acquiescence and blind following of directives, directions, orders, and rules. There is often little or no room for discretion to be exercised. (We saw a good example of this at TPS when staff applied hospital escort security measures designed for higher security prisoners on prisoners from the minimum rated prison – see below). In a 'command and control structure' staff are often afraid, and are required to obey the orders of their superior officer,

irrespective of their merit. By ‘command and control’ it is assumed that employees know where they stand, who to blame when things go wrong, there is predictability and stability, things will not change fast, tasks are delineated and workers know what they have to do and who to go to (if not they use the union). In many ‘command and control’ cultures, bullying and harassment abound, and promotion is often based on gender, and on matters other than merit.

‘Command and control’ is known to have a negative influence on an organisation’s ability to be creative and adaptive to changing circumstances. It is usually the antithesis of a people centred approach and is not at all good in understanding or managing customer or worker insight. It relies heavily on established processes, procedures and rigid policy systems. It tends to be much more reactive to circumstances rather than proactive in anticipating difficulties. It does not allow for flexibility or failure, and it strongly polices its employees’ movements. In such a culture, employees don’t usually need to understand an action or think, they just need to take the action they have been told to, in the way they have been trained. They therefore have little or no autonomy in decision making.

Further, ‘command and control’ hierarchies cannot tolerate dissent or alternative opinions. In many organisations understanding conflicts proactively usually assists good decision making, and includes soliciting differing opinions and ideas, knowing that different ideas can improve outcomes. Without thoughtful and constructive disagreement, decisions can be made without constructive feedback, without the benefit of reshaping, or reconsidering a poor decision. This sometimes makes it difficult to manage unplanned situations, and there is a need for experienced supervisors to turn to.

Employees cannot monitor or improve their own work performance relevant to expectations, and can therefore rapidly become disengaged, dissatisfied or stressed. Employees not being treated with respect or dignity, being bullied, not having an impact on the organisation or being rewarded with more responsibility means workers are very constrained, and this limits their commitment and engagement.

A ‘command and control’ culture is known to have a significant impact on an organisation’s ability to recruit and retain talent. Such a culture is generally seen as undesirable and out of step with modern workforce practices and employee expectations of how they want to manage their working life, of the working conditions potential recruits are looking for, or for job satisfaction. Within a ‘command and control’ hierarchy, the work environment can be psychologically unsafe and can be perceived as incompatible with long term job satisfaction. Those leaders who do not look after their existing workers (for example those high numbers on workers compensation) and use change strategies to keep their employees, tend to lose them. Workers no longer tolerate bullying, stress, lack of autonomy, or a ‘command and control’ leadership style. People vote with their feet and find alternative jobs, often with better pay, more autonomy, more respect, a greater sense of satisfaction and purpose, and with employers with whom they can engage.

There are numerous international studies calling for a revision of such cultures as they are not widely seen as effective, and they do not reflect modern workplace values or ways of working. Young people looking for jobs are unlikely to choose such industries where more favourable working conditions and cultures are available.

It is a necessary task of the SMT to fully appreciate and understand the changes, challenges and needs of the current labour market in Tasmania and how to respond to these. It needs to understand how the organisation's productivity and performance is necessarily linked to the skills, knowledge and talents of motivated, committed employees. The SMT needs to see how very many sectors have shifted their corporate organisational structures away from the traditional command and control hierarchical pyramid to a more productive workforce and inclusive cultures.

The description of such cultures and workplaces feels eerily familiar. The term 'command and control' was the SMT's description, not mine. The pride the SMT take in it, however, is misplaced. Their failure to recognise this is exerting a significant price, and one consequence is day to day lack of staffing, resulting in multiple failures to operate the prison as required. This long term systemic failure should be a source of concern.

Recommendation 12

Tasmania Prison Service Senior Management Team seeks external advice from a management consultant regarding the development of a change management process to replace the command and control culture into a more contemporary and effective management approach.

The Department of Justice has provided a response in relation to this specific issue. It indicated that I significantly mischaracterised the TPS's position in relation to the 'command and control' style used within the TPS. It indicated that the example provided in the formal briefing related specifically, and only, to control of incidents in relation to COVID-19 outbreaks and the successful way in which those outbreaks were managed. It flagged that it was highlighted as an example of an effective way in which the TPS manage critical health incidents, rather than as a reflection on the broader management approach adopted by the TPS. The Department stated that I appear to have taken a small targeted comment and drawn broad unsubstantiated conclusions based on that comment. The Department's full response can be found at Appendix 5.

I have certainly highlighted the TPS COVID-19 response as appearing to be world class in this report. The relevant text from the TPS briefing presentation said the following though under the heading ‘Strengths’, and I will let the reader determine if I have significantly mischaracterised the TPS’s position:

> Management of significant health events (like COVID-19 outbreaks) has been and is well managed. The TPS has strong structures in place, which can be stood up quickly, to provide support to staff where needed. The command and control nature of the TPS supports a strong effective response.

My conclusions regarding the ‘command and control’ work culture were not drawn simply from this one statement from TPS as to its nature, however, but also from my observations throughout the inspection. In the presentation itself the presenter was keen to emphasise the ‘command and control’ nature of the entire operation, and did so with a certain amount of pride. I also noted above that multiple examples of this ‘command and control’ management style and workplace culture were evident throughout all levels of the organisation. I provided one specific example relating to the use of handcuffs. If the Department requires an additional example, it should consider the TPS decision to refuse a CPHS doctor’s access to RPC during the inspection, as discussed below under the heading ‘Medical Autonomy’ and in the Custodial Inspector’s covering report under the heading ‘The removal of a CPHS medical officer’s access to RPC and the impact on medical autonomy’. It should also consider my comments under the heading ‘Responsible health authority’ below.

Remediation

There is no quick fix solution to the problems of lack of staffing, an issue now facing many organisations. The failure to reach agreement with the unions, to manage recruitment adequately, to maintain retention and look after staff appropriately over a significant period of time has collectively resulted in the situation seen today. The lack of staff has direct consequences upon prisoners who are locked down, and they could therefore be considered to have been deprived.

Recommendation 13

Tasmania Prison Service Senior Management Team seek external advice from a strategic human resources management consultant regarding the development of an effective staff recruitment and retention strategy.

With this in mind consideration should be given to Section 87 of the *Corrections Act 1997* (Tas) which provides:

Special management days

(1) The director may, subject to any regulations for the purposes of this section, grant to a prisoner, in relation to the sentence, or sentences, of imprisonment in relation to which the prisoner is in custody or that form part of a continuous period in which the prisoner has been in custody, one or more special management days on account of good behaviour while suffering disruption or deprivation -

(a) during an industrial dispute or emergency existing in the prison in which the sentence is being served: or

(b) in other circumstances of an unforeseen and special nature.

(1a) A prisoner who is granted under subsection (1) one or more special management days, in relation to one or more sentences of imprisonment in relation to which the prisoner is or has been in custody, is entitled to have the total period in which the prisoner is required to be in custody under those sentences remitted by that number of days

(2) Subsection 1 applies to all sentences of imprisonment irrespective of whether the sentences were imposed before or after the commencement of this section.

Whilst the problem of short staffing could be considered to be of an industrial nature, it could not easily be termed ‘an industrial dispute’. It might very well however be construed as ‘other circumstances of an unforeseen and special nature’. That it should have been foreseen does not mean that it was.

Consideration could therefore be given to the granting to each prisoner a day of remission for each and every day they have or have had to spend in lockdowns or segregation where no specific individual order has been made (for example as the outcome of a disciplinary matter). This would serve to assist in various ways: it would

reduce the frustration of prisoners; it would ease the pressure on staff; make the SMT and thence the Department of Justice more accountable; and ultimately will reduce the prison population somewhat (through earlier releases), thereby relieving staffing pressure. Most important of all it remediates the loss of prisoner's rights.

Recommendation 14

The Director of Corrective Services considers granting prisoners in segregation during lockdowns special management days to the equivalent time they have been in lockdown and that this time is remitted from their sentence.

The Department of Justice has provided a response in relation to the issue of lockdowns. This can be found at Appendix 5.

Governance and administration

Responsible health authority

The Department of Health (DoH) holds the responsibility for the delivery of healthcare into the prison. This is preferable than many other possible governance structures where services are delivered by custodial services. Within health services, a department (Correctional Primary Health Services) (CPHS) forms part of the Statewide Mental Health Services, which has taken full responsibility for healthcare delivery in prison. This is a contemporary model. It is not underpinned by a Service Level Agreement (SLA) or a MOU, but is informed by a Letter of Intent between DoH and Department of Justice (DoJ).

The effectiveness of the model depends on the relationship between the two main stakeholders, the TPS and CPHS. This has to occur in the context of a wider relationship between the Departments of Justice and Health. Staff at many levels thought that this relationship at present was good.

On closer inspection however, it appeared to us at least that this is an unequal partnership, with TPS holding much of the power and therefore being the primary decision maker. An SMT member confirmed that TPS is the 'main driver' of the relationship. TPS controls access for all healthcare staff to prisons and prisoners. It provides the space, the facilities, and completely controls movements of staff and prisoners. Whilst this is understandable, it places the CPHS at significant commercial and operational disadvantage, and its delivery of any contracted services is completely at the whim of TPS. Irrespective of how many staff CPHS has employed, including locums, they can only attend prison health centres or clinics if permitted, and can only see patients if they are brought to those health centres. If patients are not unlocked or not escorted or unable to attend, the permanent and contracted staff are not clinically active. It is possible for them to undertake administrative tasks, but otherwise these underutilised staff (some of whom are employed at a premium) are on some days at least, a waste of public money.

A large number of health staff said that there is a good working relationship at higher levels of the organisation, but things appear to be somewhat strained on the ground. This is because there sometimes appears to be a fundamental misunderstanding between staff groups regarding their roles, purpose and expectations. We were told that these relationships are built on trust, but that sometimes trust appeared to be absent, or only one way at best. Reports were made of some officers who did not seem at all interested in health or welfare of their prisoners and appeared punitive in their interactions. Some expressed views that certain prisoners do not deserve healthcare. One senior officer (a member of the Senior Management Team) told me that clinical staff need training in how to speak to prisoners properly, and should not speak to them like they were patients. He thought that the interactions of clinical staff

with prisoners ‘needs to be improved’ and that clinical staff speaking to prisoners could endanger staff and cause difficulties within the prison. He thereby betrayed his view that clinical staff should do what custodial staff do and come within his command and control. He did not appear to be taking into account the potential therapeutic nature of the interaction.

This assured me that some widespread role clarification for uniformed officers about what clinical staff were there to do (and not to do) would be helpful. At a fundamental level should a prisoner be just a prisoner or can they be a patient? Could they not be both? It might be helpful if a foundational Memorandum of Understanding could be drafted between CPHS and TPS (rather than the existing memorandum of misunderstanding). This needs to address the difference in roles and cultures operating within each organisation. This might support processes of cultural development especially across the interface where sometimes these cultures have the potential to cause tension and misunderstanding.

Recommendation 15

Training be provided for correctional staff about the role of health staff and vice versa.

Equally there is a danger that health staff can become health fatigued. Reports were made by some prisoners that sometimes health staff appeared to be unkind, brusque or sometimes punitive and rejecting in their responses to them. Kindness as a commodity is not valued by all. In some cases staff who have been working in the prison for lengthy periods are in danger of absorbing some of the punitive attitudes that pervade the atmosphere. This is particularly the case where staff are tired, feel unappreciated, become disengaged, and want to identify with the much stronger, tougher and more ‘macho' culture that some officers have, which they see as somehow more desirable, if only to fit in and be ‘hard’. It takes resilience, strength, courage, support, ongoing training and supervision to ensure the therapeutic culture that exists with health is not eroded. It seemed to the inspection team that in general the health therapeutic culture is strong, but in some spaces, most notably in RPC, it is becoming frayed around the edges. It needs attention.

It is time for consideration to be given to revamping the Letter of Intent between the two organisations.

Recommendation 16

Review the Letter of Intent between the Department of Health and the Department of Justice, and this to be shared with all staff from Correctional Primary Health Services and Tasmania Prison Service.

Medical autonomy

'Autonomy' in medicine usually refers to the fundamental ethical principle that competent adults can make informed decisions about their own medical care. Of course within the prison environment where much individual autonomy is stripped away, it is especially important that medical autonomy is maintained. In the prison setting, another aspect of medical autonomy needs a special mention; that of the autonomy of the medical practitioner to practice in the best interest of their patient without interference from custodial staff.

In some jurisdictions prison rules exist which allow a superintendent to order a doctor to administer emergency medical treatment to a prisoner. In practice this is nowadays very rarely if ever used, but the power that exists could be a significant erosion of the autonomy of the medical practitioner to practice in the way that they professionally deem necessary in the circumstances. Fortunately this provision appears to be absent in Tasmanian Prison Rules. Several doctors during the inspection told us that they enjoyed complete autonomy to make the medical decisions they needed to make in order to treat their patients.

During the inspection, however, the fragility of this was highlighted when a permanent member of health staff – a medical officer – was without warning denied entry into the prison to work. It quickly emerged that it was because the doctor had made a clinical decision the previous day with which the TPS didn't agree.

The issue had been whether a female prisoner from MHWP, who had previously been admitted to RHH because she had swallowed a razor blade, should return to the prison Inpatients Unit for observation, or remain at RHH for a few more days. Either way she would require daily x-rays at the hospital. The medical officer's view was that the observation planned at the Inpatients Unit would not be sufficient to guarantee the patient's safety, because at any time medical complications might ensue as the razor blade passed through her gastrointestinal system and urgent intervention would be required which could not be delivered in the Inpatient Unit. The medical officer's view was that the patient needed to remain at RHH, but TPS wanted to return her to the Inpatient Unit.

As a consequence of the medical officer reaching this decision on clinical grounds, considering the needs of the patient and in all good faith, the TPS decided to withdraw the medical officer's right to enter the prison the following day because they had disagreed. Neither the medical officer nor their manager were told of this prior to them being refused entry. When the medical officer had arrived at the prison gate, in full view of the public, a junior uniformed officer advised them that a ban was in place preventing their entrance. No explanation or reason was given. The medical officer was deeply shocked, humiliated, intimidated, felt undervalued having worked extremely hard, and was not treated with any respect or professional courtesy. The medical officer was distraught (reported as inconsolable) and, being a permanent member of staff, was worried about job security. The medical officer wondered what the reason might be. The medical officer seemed to be otherwise highly regarded by Health, TPS staff on the ground and by patients.

The decision had been made by the Director of Prisons the day before. This was not communicated to the medical officer or the direct line manager (the clinical director) or the group director of the service. The clinical director was worried about the implications for the autonomy of clinical decision making, and wondered "who was next". Correspondence seen by us between SMT members suggested that there had been 'issues' with this doctor on previous occasions. The clinical director and group director were unaware of what these might be because no concerns had ever been communicated to them. As the inspection team were present when this occurred, we were then told that a meeting was to be scheduled the following day, and if the medical officer apologised entry would then be permitted. On that day the medical officer was effectively also denied access to the inspection team.

A senior member of staff later said that they were disgusted by what had happened and were ashamed to be wearing their uniform today. They said they were not surprised as 'they do this sort of thing'.

It also emerged that a senior operational staff member of TPS had allegedly previously threatened to ban another member of clinical staff. This allegation was denied.

A copy of the correspondence referred to above, which had been sighted by the inspection team, was requested and eventually provided. The email from the Director of Prisons to CPHS management stated:

> "If a professional from another agency cannot work constructively with us, I see little value in them having access and indeed such behaviour causes greater risk of unrest for all."

This event illustrates a number of issues about the pervasive culture at the prison. Furthermore this treatment of a professional may not be isolated ('they do this sort of thing"). This is an astonishing way to treat any professional, not least someone who

is not a member of TPS staff. It betrays the power imbalance between the CPHS and TPS such that it cannot be a proper partnership. It demonstrates how the lack of understanding about the role of doctors and healthcare staff and the principles under which they work goes to the very top of the organisation. It shows a dramatic lack of respect not only for the medical officer, the medical officer's line management, the director of SMHS, but also the entire health team. It is not a good way of retaining professional staff. It illustrates the profound lack of acceptance (or ignorance) of the basic principles which underpin the delivery of healthcare services in custodial environments.

Irrespective of the issue at hand, there are so many more constructive ways in which this situation could have been handled. The way that was chosen undermined confidence and trust not just of that medical officer but the entire health team, trust that will probably take a considerable period to be restored. It will provoke all medical professionals to question their judgements, and to wonder if they make a decision TPS might not like, might their jobs be next. If so, they may not decide what needs to be decided in the sole interests of their patients, and thereby undermine their independence.

Response from Director of Prisons and the Department of Justice to 'Medical autonomy'

I have reviewed comments from the Director of Prisons and have noted his objections to this section of my report. He wrote that the matter was not reflected accurately throughout the report, particularly that my report in this respect was inaccurate, and lacked detail and was not acceptable. He asked that this aspect of my report be removed. In response, the inspectorate asked for further details of these objections, and for the details of the concerns of others to which he also alluded.

The Director responded that I had not taken the perspective of TPS into account in my report or that RHH considered that the patient was ready to be released and could be brought back to prison. His response included the phrase that the doctor was not supportive. He also raised other matters that also informed his decision to exclude the doctor. He also expressed disappointment that I reported what a senior officer told the inspection team on the day about their views of what had happened, and that there was no context to support this claim. He wrote that he would 'happily discuss this with the said manager'.

Whilst I understand that the Director may wish to discuss the matter with the senior officer, it is one of the reasons I decided to withhold this person's name from my report, as indeed I did with most people who talked to the inspection team: people should be able to tell the inspection team what they think. This does not mean that what the person said was less valid. When writing the report I did take into account

the events at the time and the justification of TPS for their decision making, so their perspective was included.

I have also considered the additional information the Custodial Inspector obtained following the inspection, which is detailed in the Adult Health Care Inspection Report 2023. The Director's comments and the additional information have not caused me to change my opinion as expressed above. My report should, however, be read in conjunction with the additional information from the Custodial Inspector. I would also like to take the opportunity to invite the Director to reflect on the extent to which his responses to this section of the report reflect the principles set out earlier in my report. It is an important part of the inspection process to allow interested readers to reach their own conclusions relating to this issue and the others that the report raises.

The Director was given an opportunity to provide a formal response to the above and said:

> *In my view, a number of issues remain with this aspect of the report, and factual inaccuracies - and a lack of balanced reporting – are retained.*
>
> *Dr Petch asserts that "the TPS wanted to return [the female inmate] to the Inpatient Unit". This is not wholly correct. The TPS was acting on advice from medical staff at the RHH who had cleared the prisoner for release back to the prison. The TPS advised the doctor that if the patient returned, staff could then conduct other medical appointments locally. The issue was broader than the TPS simply disagreeing with the doctor for the sake of an unlock, and was motivated by a desire to get better health outcomes for more prisoners.*
>
> *Statements such as "it quickly emerged that it was because the doctor had made a clinical decision the previous day with which the TPS didn't agree" are asserted as fact rather than being acknowledged as Dr Petch's opinion. As you* [Custodial Inspector staff] *know from my conversations with you, a number of factors led to the doctor's access being denied; it was not on the basis of a single clinical decision. Indeed, the incident cited by Dr Petch was just one of a number of matters raised regarding the doctor's actions (which I acknowledge were perceived as unhelpful) which were seen to create a potential risk to the safety of staff, including the doctor herself, and prisoners. As you* [Custodial Inspector staff] *are aware, and have reported in your corresponding section in the report, it had been reported to me that while physically present, the doctor declined to see patients with appointments during the time the clinic should have been operating, which I am told caused significant agitation amongst the SRC prisoner population. This incident had the potential to be a flashpoint between prisoners and staff, including the*

doctor. Dr Petch is silent on this crucial information which directly informed the TPS's decision.

He also does not present information that was reported directly to him and the Inspectorate as to how it was intended to divert the doctor to a meeting with the General Manager from the point of entry to the prison. While I have openly admitted that the way the event ultimately transpired was clumsy and regrettable, I have also made it clear that that was not what I had asked to occur. The omission of this information unfairly implies that the TPS, and indeed myself personally, intended that the doctor be subject to a demeaning public refusal of entry and be denied professional courtesy; that was far from the intention.

Another point worthy of note but absent from Dr. Petch's report is how quickly I acted to address the impact on the doctor, apologised for any distress caused and quickly re-established professional and productive relationships both with the doctor and more broadly CPHS.

In his clarifying paragraphs, Dr Petch states that I asked for this aspect of his report to be removed. This, too, should be clarified. I originally asked for it to be removed in its current form and urged that it more accurately reflect the full and balanced picture of what occurred. This is an important clarification. Without it, the phrase misleadingly implies that I sought to prevent these events coming to light; that is not the case.

Contrary to what is implied in Dr Petch's clarifying paragraphs, my intention in seeking further clarification and information in this aspect of the report was not to change Dr Petch's opinion as expressed, but to ensure that the 'interested reader' has a full and accurate account of what occurred. Otherwise, any resulting conclusions are flawed.

When the Director was initially asked for clarification of his objections to my report, which I have summarised above, these additional points in his formal response were not raised. However, in considering these additional points they do not prompt me to change my opinion.

The Department of Justice has also provided a formal response to this issue and it can be found at Appendix 5. The Department has said that crucial information remains absent from the report but then proceeded not to provide it in its formal response, despite having the opportunity. As I said above and as the Custodial Inspector also noted in his cover report, my report and the Custodial Inspector's coverage of this issue should not be read in isolation.

Despite the objections raised, I stand by this section of my report, despite its contentious nature and the fact it has not been accepted. The key issue for me is that moving forward, the autonomy of medical staff should be respected, and the nature, strength and extent of the disagreements with regards to this aspect of my

report by both the service and the Department does indicate that this is recognised, which is very welcome. It is hoped that great care will be exercised should similar situations arise in future.

Administrative meetings and reports

In order to maintain the operational relationship between TPS and CPHS there are regular meetings between the SMT and the CPHS in which operational matters are discussed and progressed. Both seem satisfied with this arrangement. However, they are making decisions based on old data from previous months rather than up to date information with the potential to be more useful.

There appears to be a wide agenda. Minutes are kept. Are matters progressed? The agenda appears to be based on a TPS agenda of running the prison. This is different to what might usually be seen in a clinical governance agenda where continuous clinical improvement is the driver (see below).

Policies and procedures

Many staff commented that the policies and procedures in place were out of date and had not been reviewed for up to a decade. This clearly needs attention. There is a State Mental Health Policy and Procedure meeting, but this issue may not have been addressed.

Recommendation 17

Tasmania Prison Service to bring all standard operating procedures and Director's Standing Orders relating to healthcare services up to date and keep them under review.

Continuous policy improvement programme

There appears to be a clinical governance quality improvement program/safety and quality agenda just alive at the prison. Essentially clinical governance is a framework of which there are a number of components whereby standards of health are continuously examined and improved through cycles of audit and monitoring to ensure all aspects of care are maintained.

These components usually consist of:

- clinical effectiveness, assured through evidence based practice, use of guidelines and research activity;

- risk management, the minimisation of risk to patients through identification of problem areas, learning from previous incidents, use of risk assessments, registers and use of risk systems;
- involving patients and the public in forums, feedback and acting on complaints;
- audit;
- staff management – continuous professional, performance management and credentialing;
- education and training including mandatory training and systems to ensure all are up to date; and
- information and data systems.

Such a clinical governance meeting needs to be active and meet regularly to keep abreast of the broad agenda. The CPHS Clinical Speciality Group met only three times in 2022 and four times in 2021. Senior custodial staff should be present to facilitate the changes that need to be made. The driver behind this meeting should ideally equally be CPHS, following a health driven agenda, with a multidisciplinary clinical governance focus. Given the issues encountered by this inspection, it may assist CPHS to address the challenging agenda if these meetings were held more frequently.

Recommendation 18

Correctional Primary Health Services Clinical Specialty group needs to meet at least six times per year.

Emergency response plan

We asked if there had been any scenario planning involving health staff in the event of a major event (such as a riot or major disaster) where multiple people (including staff) may require urgent medical attention all at once. CPHS indicated that they did have an emergency response plan which includes the ability to expand their operational area to take in areas external to Outpatients and centralise staff from other prison sites. There is also an Emergency Management Group at RHH that can be mobilised if required in a major disaster.

Communication of patients' health needs

A system operates where patients make their medical requests known through the completion of a form. This is not easy for people without the ability to read or write,

or those with specific disabilities. Sometimes other prisoners or carers have to help them. When a request is made, the paper is sometimes posted or handed to TPS staff, or handed directly to CPHS staff. There can be several weeks then when nothing happens. It appears that the request is not acknowledged in any way. The patient does not know whether the request has even been received. They may therefore put in a further or several further requests. Sometimes it is several weeks before a patient is seen. Many requests to see the doctor are triaged by the nursing team, sometimes without seeing the patient but by reference to the request and the notes. If no further action is required, this is not fed back to the patient who is left wondering what is going on. This is at best impolite.

A system of feedback to the patient who has requested a service needs to be developed.

Recommendation 19

Correctional Primary Health Services acknowledge patients' medical requests and give a date by when they will be actioned or reasons why they will not.

Privacy of care

It is challenging to always maintain the privacy of prisoners during healthcare consultations and procedures whilst also maintaining security. This is especially so outside the prison where the infrastructure (such as that in many hospitals) was not designed with security as a foremost consideration. In general, custodial staff appear to try as much as possible to maintain their distance during consultations.

A recent escape from hospital of a patient (which eventuated in that patient's alleged murder in the community several hours later) illustrated how difficult it is to get this balance right. The security of escorts is discussed below, but the tighter the security that is required, the less privacy in general that can be afforded a patient whilst being treated. Often custodial staff are in the clinical room with the prisoner to maintain safety, and this is judged on a case-by-case basis.

Medical notes are kept separate from custodial notes and cannot be accessed by custodial staff. This is appropriate.

When prisoners at RPC and the SRC are required to attend for an appointment, their name is announced on the loudspeaker so that all prisoners know when someone is attending the health centre. This erodes their privacy, but also increases the risks of other prisoners becoming aware of who is receiving treatment, and therefore who

might be able to supply drugs. Perhaps other ways of alerting prisoners to their appointments could be found without telling the entire unit.

Recommendation 20

Alert patients of their medical appointments without announcing it to the entire unit.

Procedure in event of a prisoner's death

The role of TPS and CPHS, in the event of a prisoner's death, are outlined in the emergency operating procedures for each facility.

Grievance mechanism for health complaints

All prisoners are told how to make complaints about health. We were satisfied that prisoners know how to make a complaint. There are multiple mechanisms whereby a complaint can be made:

- directly to CPHS;
- directly to TPS via unit supervisor;
- via TPS complaints form;
- Health Complaints Commissioner;
- VRC via phone or email;
- Anti-discrimination Commissioner; and
- Ombudsman.

Some prisoners stated that after their medical appointment has been cancelled (so often) and their repeated requests ignored, they have resorted to calling the Health Complaints Commissioner to complain, and only then do they get a service.

Some of the information sheets issued to prisoners about the complaints process are dropping the word feedback, as this has the potential to confuse and obfuscate the fact that a complaint is being made.

The inspection team were told variously that all complaints are registered and resolved. We were informed that complaints are logged through the Safety Reporting and Learning System, as a THS requirement. Complaints are also documented in the patient's notes. This may not always be appropriate, for example if the complaint is about a particular practitioner. We were told that all complaints are responded to.

On closer inspection this may not always be true, or at least the feedback does not always seem to reach the prisoner. Many prisoners told us that there is little point in complaining because the complaint is ignored, there is often no acknowledgment or feedback, no investigation and nothing ever changes. Prisoners appear to routinely complain straight to the Health Complaints Commissioner regarding health matters rather than first using the internal complaint process. This is inefficient as many complaints could be resolved faster with an effective and properly resourced internal complaints process.

Recommendation 21

Correctional Primary Health Services acknowledge the receipt of complaints and provide a date by which they will be investigated and if appropriate, actioned.

A large proportion of complaints are about poor pain management and paracetamol in particular, medication, opiate replacement therapy (ORT), dental wait times, and diet related matters.

Disappointingly no one in senior management roles in the CPHS could identify a single way in which a complaint had led to a recent service improvement. Further the question was met with the response that that this is not what a complaints process is for. This response suggests there is a missed opportunity to improve services or to at least maintain continuous service improvement arising from complaints. Complaint investigation, recommendations, action, and audit of that action is a necessary part of this process.

Recommendation 22

Feed findings from complaints into the Clinical Speciality Group for introduction into the clinical improvement process.

The complaints management system needs review, as it does not seem responsive to prisoners, it does not appear to be used to generate understanding of flaws in the service and thereby identify how to remedy them, and does not meet best practice in clinical governance terms. It might assist the CPHS development of the complaints process if there was a regular minuted meeting between CPHS and the Health Complaints Commissioner.

Recommendation 23

Correctional Primary Health Services to establish a regular meeting with the Health Complaints Commissioner to discuss complaints, trends and outcomes.

Staffing

As with almost all other areas within the prison there have been staffing shortages in healthcare although there has been some recent recruitment just before Christmas 2022. This staffing shortage is causing disruption to service delivery. Although lockdowns are disruptive to clinics, they are not the sole limiting factor to long waiting times for appointments and delays to treatment.

The nursing roster is organised into 12 hour shifts, with staff generally working three days on followed by three days off through a central rostering system. Some work nights usually three nights on and three off. Some night staff are semi-permanent on nights. On any day there are ten nurses rostered to work in the day and two at night. This is usually sufficient. Staff said that there was usually sufficient flexibility in working arrangements and most expressed satisfaction.

Current nursing staffing gaps include three needed at RPC, one at SRC, one at MHWP, one at RBP and one at HRP. We were told that recruitment to nursing positions at the prison was okay and that these shortages were fairly normal. They also reflected nursing shortages elsewhere. There are however insufficient mental health nursing positions.

There is no Indigenous health care worker despite approximately 20% of the prison population being Aboriginal (compared to 5.97% Aboriginal and/or Torres Strait Islander people in the Tasmanian community).[39] This needs to be rectified.

Some anomalies in staffing were identified in the reception prisons. For example, in LRP there are two nursing positions whereas in HRP there is only one, although the workloads appear to be similar. Staff at both sites stated that work intensity in the reception prisons was variable, and was particularly busy during summer months and over specific holidays when arrests are more significant – particularly after public events or mass gatherings where drugs or alcohol have been consumed such as New Year. TPS has extra staff rostered for these occasions: perhaps consideration could be given for nursing staff too.

Credentialing

It was not clear that these were checked on an annual basis.

Clinical performance enhancement

There was little evidence of clinical supervision offered for any staff.

[39] Australian Bureau of Statistics (2023)

Continuous Professional development

Mandatory training is provided. We were informed that staff training for six weeks in various placements was provided on request.

Recommendation 24

All Correctional Primary Health Services health staff need access to peer support and supervision, training, skills and career develop opportunities, cultural diversity training, and regular updates in clinical practice.

Health training for correctional officers

It appears that none is provided other than first aid and mental health first aid training.

Safety

Infection prevention and control

Immunisation is a simple, safe and effective way to protect individuals, families and communities from serious diseases. The National Immunisation Program[40] and Tasmanian Immunisation Strategy 2019-24[41] provides free vaccines against a number of diseases, to increase immunisation rates and reduce vaccine preventable disease. The vaccination recommendations outlined in these two documents include groups within the youth and adult custodial populations, for example, individuals under the age of 26, pregnant people, Aboriginal people, and individuals over the age of 65.

CPHS staff at AYDC indicated to the inspection team that they provide catch-up vaccinations and COVID-19 vaccinations to young people entering the facility.

CPHS staff working within TPS indicated to the inspection team that all prisoners are routinely offered vaccinations for HBV, influenza and COVID-19. Other immunisations are offered to specific groups: Gardasil (human papillomavirus) for under 25 year olds, pertussis (whooping cough) for pregnant people, ADT (diphtheria-tetanus) if required following wounds or lacerations, and pneumococcal and Zostavax (shingles) for over 70 year olds. Offering available routine vaccinations to custodial populations is a good public health undertaking, as these populations generally have lower uptake of preventative healthcare in the community.

COVID-19

This was an area which was clearly tested over the last three years in light of the COVID-19 pandemic. Overall, the response to the risk appears to have been world class. A team of correctional officers and medical staff developed policies and procedures with the relevant departments and stakeholders (such as the Tasmanian Public Health Emergency Operations Centre). These policies were comprehensive and prompt, and were adhered to closely. Overall, they resulted in the minimal rate of infection among prisoners, and where breakouts were detected, they were managed well and contained. Adequate levels of PPE were available. The vaccination rate amongst prisoners was the same as in the community.

Tasmania overall, after the initial Australia wide response, had only two regional lockdowns during the pandemic: 14 days in North Western Tasmania (April 2020) and three days in Southern Tasmania (October 2021). When borders were reopened after a significant period of closure, cases did enter the state and there was subsequent community transmission. There were no cases detected in the prison

[40] Department of Health and Aged Care (2023)
[41] Department of Health (2019)

during 2021: it was only after the borders reopened that cases in the prison began to emerge. The first were in the O'Hara cottages in January 2022 when two prisoners tested positive. The cottages were isolated. Infected prisoners were required to isolate for seven days. The two prisoners were sharing with two others who also became infected – the breakout reached eight prisoners in total.

A number of subsequent breakouts occurred. One unit was designated for COVID isolation at the height of the pandemic. The management of later outbreaks improved as the lessons from previous ones were learnt. Overall, 229 prisoners contracted the infection, some (128) more than once, so the number of positive cases was 356. Communication went well and people responded positively. Prisoners also responded, understood and for the most part complied with measures being taken.

All staff testing positive (73 overall) obviously stayed at home and were required to isolate for seven days. Out of 500 staff only three did not have the mandated vaccinations, and these were stood down.

There were visitor restrictions during the pandemic which had the incidental effect of reducing drug availability in the prison. This helped the SMT to acknowledge that the opiate replacement program, which continued as before, was not the source of most of the drugs circulating within the prison (see below).

The prison staff, SMT and CPHS appeared to be genuinely proud of the work done in containing the pandemic and preventing the explosion of cases that had been expected by all and which occurred in prisons in most other jurisdictions. There were very few infections or hospitalisations, and no deaths. Isolation worked well.

This is an example of good practice, and the response should be disseminated so others can benefit from the Tasmanian experience if there is a recurrence.

Use of single cells

The use of single cells for the majority of prisoners is welcomed by most prisoners. Single cells are safer for prisoners and for the most part improve quality of life. The opening of the SRC had a significant impact on reducing the number of double up cells.

Response to physical and sexual abuse

At the time of this inspection, the Commission of Inquiry into the Tasmanian Government's responses to child sexual abuse in institutional settings had concluded their hearings. Part of the scope of this inquiry focused on the response by the

Department of Communities Tasmania (now Department for Education, Children and Young People) to allegations of child sexual abuse at AYDC.[42]

Young people can report assaults to either AYDC staff or CPHS staff. They are also able to report assaults to the Commissioner for Children and Young People directly or through their advocate located at AYDC.

The procedures for responding to physical and/or sexual assault of a prisoner are detailed in the Emergency Operating Procedure for each TPS facility. These procedures include seeking medical treatment and contacting Tasmania Police.

Any reports made of sexual assault is taken seriously by TPS and health staff. Prisoners are referred to the police who undertake any necessary forensic examination at RHH. Prisoners are then routinely seen by the TSU staff and SASS is also contacted.

SRC yard

The provision of shade in the yard areas of SRC is inadequate and needs a redesign. Positively, sunscreen is provided.

Recommendation 25

Provide more shaded areas to the yards in the Southern Remand Centre.

Use of force

There is a regular review of use of force by a review panel chaired by the Assistant Director of Prisons. The panel consists of a minimum of 4 representatives, of which two must be suitably trained in the application of force. The membership includes:

- Assistant Director, Intervention and Reintegration Services
- General Managers (by prison)
- Superintendent, Emergency Management
- Workplace Health and Safety Manager
- Audit and Compliance Supervisor
- Control Restraint Instructor by rotation
- Union delegates (observation only)

[42] Commission of Inquiry into the Tasmanian Government's responses to Child Sexual Abuse in Institutional Settings (2023)

- Other persons may be invited to participate, including observers and guests, at the discretion of the Chair.

There is no community member. This panel seems to have been recently rejuvenated, potentially as a result of complaints received by oversight bodies, having been relatively neglected for a while. The Panel reviews all use of force incidents apart from those involving watch-house detainees and those involving young people. The relevant Superintendent/General Manager reviews use of force against watch-house detainees and they also review use of force against young people, provided they meet the necessary gender requirement.

It is very important that each and every use of force is reviewed by such a panel, to ensure it was justified, applied correctly and according to safeguards, and procedures, and any untoward outcomes analysed. The other role of the panel should be to maintain statistics and identify trends (i.e. increases or decreases in its use, maintain comparisons between similar units and to other jurisdictions), identify problems arising in techniques and monitor injuries to staff and to prisoners. It is understood that a new incident management system is being introduced which will assist in some of these. These reviews and the work of the panel should be prioritised and not lapse again.

Recommendation 26

Review the terms of reference, including operation and membership, of the Use of Force Review Panel with the view to increase community input, including the Tasmanian Aboriginal community.

The use of CCTV is often helpful in conducting these reviews. CCTV, however, provides only limited views and angles and does not provide sound, which might assist in understanding the context and the circumstances of escalation, and any steps taken in de-escalation before force is used. Consideration should therefore be given to the use of body cameras as now required by many police forces. These could be either on at all times (ideally) or activated when necessary. They could be used in all areas but particularly in high and medium security and in the reception prisons and AYDC. There are a significant number of use of force incidents at HRP and LRP as 201 of the 430 use of force incidents in 2022-2023 financial year involved watch house detainees so there would likely be significant benefit in their use at these locations. The Dedicated Response Team, which is called upon during prison incidents where use of force may be required, also ought to have them as standard issue as they were involved in 79 use of force incidents during that period.

The Tactical Response Group, which responds to serious incidents in the prisons, has helmet cameras which provide audio.

Systems for body cameras are readily available and have been shown to be effective in allowing thorough review and increasing understanding of how and why use of force is occurring. Body cameras would also make officers more accountable for their actions, it would enhance their physical safety (and reduce workers compensation claims and time away from work with injuries) and the safety of prisoners. Further it would help prevent situations spiralling out of control if prisoners and staff knew they were being recorded. It would help evidentially in the event of prison charges being brought. It would enhance training opportunities through review. It would reduce abuse (both ways). It would make subsequent decision making more transparent and equitable. It would overall enhance scrutiny. It might also assist in the reduction of bullying between staff.

Recommendation 27

Provide, as a minimum, the Dedicated Response Team and officers working with watch-house detainees with body cameras.

If it is the aim to use force as rarely as possible, (and it should be because this is when staff and prisoner injuries can occur), careful consideration should be given to routinely gaining the perspective of the prisoner once the situation has calmed down, say the following day. The experience of being restrained is unpleasant for all, and calm reflection afterwards may assist in leading some prisoners to realise alternative options are available which might avoid the need for use of force if similar situations recur. These reflections might also allow the panel to gain a deeper insight into how the incident unfolded and whether from their perspective other options may also have been available.

Recommendation 28

Obtain prisoner perspectives after every use of force so they can be fed back into the review of the incident.

The rate of injuries on staff and prisoners during the use of force and assaults between prisoners (including broken teeth, need for hospital care or ongoing medical care, need for stitches, sexual assault and even a prisoner rendered unconscious) is escalating, particularly in medium security. This is a source of concern. Violence reduction strategies do not seem well developed.

Recommendation 29

Review the violence reduction strategies that are in use to ensure they are contemporary.

The use of force against juveniles needs particular scrutiny and care, and special training. Highly volatile situations can develop very quickly, and can be very dangerous. Several incidences in different jurisdictions have been shown publicly and caused state, national and international level shock, opprobrium and embarrassment. During our inspection an alleged unreasonable use of force incident against a young person at AYDC was brought to our attention. It was raised with management and positively, the response was immediate. The staff member involved was stood down, based on the CCTV footage, whilst the matter was investigated.

Staff safety

The figures from the body within the Department of Justice which manages workers compensation, (the State of Tasmania is self-insured), told us that 60 members of staff from a workforce of 580[43] (10.3%) are permanently incapacitated. Approximately half of these people are suffering from physical problems and half from mental problems, some with a combination. A good proportion of these were traumatised or bullied, or burnt out. 10.3% of a workforce permanently incapacitated due to a workplace injury is high indeed for any industry.

There are 145 open workers compensation claims from TPS (178 from the Department of Justice as a whole). Many of these are under investigation to determine whether claim for liability will be accepted. The time allowed for determination of liability is 84 days. Many of these workers are on light-work duties or on return to work programs. A few have non-compensable injuries. Some claims are associated with grievances, others with breaches of contract or performance

[43] TPS employed 130 non-correctional staff and 450 correctional staff as at 31 March 2023. The number of permanently incapacitated staff was provided to the inspection team in February 2023.

management issues. A few events resulting in injuries appear to have affected multiple staff.

There are a number of potential reasons so many people have claimed workers compensation. These figures strongly suggest that psychologically, culturally (see above) and physically TPS provides a hazardous work environment. Senior staff suggested that the rate of claims has increased because staff are less tolerant and resilient than they once were. There is little or no evidence for this. If anything, the anecdotal evidence given to the inspection team suggested that people only make claims as an absolute last resort when other avenues for their difficulties have been exhausted.

One issue that may be perpetuating the length of time people stay away on workers compensation is the way the compensation is calculated. It takes the average pay that was made to the worker in the weeks before the claim was made, including all overtime, and pays at that rate during the period on workers compensation. If overtime was substantial, the weekly rate paid whilst on compensation may be substantially more than the person would receive if they returned to work. This makes rushing back to work after an injury much less attractive and encourages people to stay away. It is not known to what extent this has swelled the numbers of those considered permanently incapacitated, but the compensation payments can last up to nine years.

A potentially more important issue is that many people on workers compensation appear to suffer from post-traumatic stress disorder and are finding it very difficult to access treatment for their conditions in the community. The duration of their illnesses appear to be prolonged, so some people's incapacities are thought to be longer than they would have been had more treatment been available. This is presumably the case for every industry and for the community as a whole and is a matter for the Tasmanian Government to consider.

Recommendation 30

The State Government to consider how people on workers compensation can access the psychiatric care they require.

The injuries sustained during staff training are a good indicator of whether control and restraint techniques used by officers are safe. The rate of injuries seems to have moderated somewhat since training was purchased from trainers from New Zealand using the techniques used over there.

Support provided to those making claims has very much diminished of late which is potentially detrimental to the swift resolution of claims and effective communication. A role in the workplace health and safety team was allegedly rescinded due to a perception that the provider of this support may have been pushing people towards making workers compensation claims, but their role was to provide people with the necessary information to make an informed choice. Lack of support is likely to make workers compensation claims more likely because people are no longer being supported back to work. Often the support that was provided would have likely dissuaded people from making claims and assisted them back to work instead of pursuing claims.

Recommendation 31

Consider how best to support people on workers compensation or sick leave especially in light of the Wellbeing Officer role no longer being funded.

Patient care and treatment

Information on health services

When prisoners arrive they are given information about the healthcare services that are available and how to access them.

Initial screening

Sometimes police detainees are brought into reception prisons too unwell to be detained in custody and require immediate medical attention. We were told that the police sometimes know this, and rather than take the detainee to hospital themselves, hope that responsibility will be shouldered by the reception prison. The staff at HRP stated they were very alert to this possibility and prided themselves on undertaking a basic triage of detainees immediately on arrival and rejecting them if they are deemed to have been injured, or are dangerously intoxicated, agitated or unconscious. The police then obtain appropriate medical intervention for them.

At the reception prisons there is no 24 hour nursing coverage but there is an on call-person who can attend as necessary, for example if patients become agitated or disturbed or staff become concerned after they have been received. If they enter after hours, most cases would be assessed the following day. There can therefore be delays of up to 12 hours before initial assessment if the person has been received overnight. The risk during that period can be considerable. Given evenings can be busy periods, particularly before, during and after public holidays or sporting or special events with mass gatherings and widespread consumption of alcohol and other substances, this risk might be lowered by extending nursing hours in reception prisons to cover these higher risk periods.

Recommendation 32

Consider increasing nursing staff on duty in Hobart Reception Prison, as is done with correctional officers, during evenings and nights when there are public events likely to involve large crowds and substance use which may result in high numbers of arrests.

There appears to be a robust system of initial, nursing, medical and mental health screening in place. We heard from some prisoners who told us that they had to wait

to see a doctor for six weeks after their arrival. It would be helpful for CPHS to conduct an audit of their screening processes to ensure universal coverage, and that all appropriate referrals had been made and follow ups arranged.

Medication

The use of prescription medication in prison presents particular challenges which need to be overcome. Once medication is prescribed (a process in itself), clearly the next stage is to ensure the right medication is available to be prescribed (i.e. is on the prison formulary). The next most complex process is largely one of logistics, ensuring that each individual prisoner receives the correct medication at the correct time, at the right place, in the right form and at the right dose. It then needs to be administered with sufficient security to ensure the medication is actually given, and is appropriately recorded as having been given. If any one of these stages is overlooked, the integrity of the process is lost. All parts need to work together.

Prescription Medication availability (formulary)

Many clinicians within healthcare stated that in one way or another the current formulary is too restrictive. The range of medication available should approximate to that available to members of the general community. That is to say that people in prison should not be restricted in their access to medication simply as a consequence of their imprisonment. To a very large extent this is indeed the case. Where medications are restricted there needs to be a very good reason for this. One reason might be cost (say of a particular brand over another) or its trafficability. Practitioners may be told not to prescribe certain medication, even where it might otherwise be clinically indicated. In my view this is largely inappropriate but in some instances can be justified. It is not always a strictly medical issue but could be a custodial one, and consideration needs to be given as to how this problem can be more effectively overcome.

Drugs and Therapeutic Committee

Decisions about procedures and practise regarding prescribing and delivery of medication are best made through a formal Drugs and Therapeutic Committee, which would sit within the health governance structure. There is currently no such committee. The committee's role would be:

- overseeing formulary development and decision making,
- the influencing of prescribing practice and use of disease management guidelines,
- delivery of prescriber education, and
- data analytics of medication use.

One example where such a committee would aid prescribing within CPHS is the long acting stimulant drug Lisdexamfetamine. This first line treatment recommended in the management of ADHD is not currently available in the formulary. This issue is addressed directly in the new Australian ADHD treatment guidelines, released in 2022.[44]

Recommendation 33

The Medication Management Committee / Drugs and Therapeutic Committee should ensure all aspects of prescribing practice are in accordance with an established set of clinical guidelines for prescribing in correctional settings. Prescribing guidelines need to be developed where these differ from community treatment guidelines. A formulary needs to be agreed with clinicians.

Prescription of medication

The first impression that some prisoners get of health services after they arrive in prison is sometimes unfortunate. Some prisoners stated that even when on well-established medication prescribed by their own GP or specialists for previously diagnosed conditions, without any consultation with them or any notification or discussion, the medication with which they were happy and stable is stopped and an alternative prescribed. Sometimes their medication is stopped and not replaced. The concept of continuity of care on entry into the prison is thus put aside. No consideration is given to the remanded patient who may be rapidly or unexpectedly returned to the community. There may be many valid reasons why medication is not continued in prison (see below), but there are no valid reasons why it should occur without clinical discussion and explanation with the patient. This is bad medical practice and needs to be reviewed.

Sometimes there can be significant gaps of several days or up to a week before medications which were stopped on arrival are resumed. It can take several days or weeks for stability to be re-established. In the cases of chronic medical conditions (for example chronic pain) or mental health conditions, this gap can provoke relapse or deeply unpleasant discontinuation symptoms. Some patients are very sensitive to the smallest medication changes. Some medication that is stopped is addictive, and sudden stoppage rather than gradual withdrawal (as is recommended) can add to the distress of the first days of incarceration and to the withdrawal from other

[44] Australian ADHD Guideline Development Group (2022)

substances that many will be experiencing. In addition, the person may be distressed or anxious about their new circumstances (the removal from home, the new environment of prison, and their new legal circumstances).

Why any changes have to occur immediately after arrival was not explained. In fact, it makes little sense to make changes at this point, because it will take several days for any illicit drugs that have been taken to be fully metabolised, and the elimination of illicit drugs may gradually resolve some symptoms presented by the patient. Allowing time for appropriate observations to be made, withdrawals to occur, diagnoses to be clarified, contact with community providers to be made and consultations with the patient to occur would all improve practice in this regard.

Two reasons for stopping or altering medication on arrival were provided. The first was that prescribing in the community is not always according to best practice and is sometimes unnecessary. For example, there may be poly-pharmacy where multiple medications for the same condition is being given. Medication levels may have been determined when the person was taking intoxicating substances or smoking, and so its effectiveness may have been compromised. The given diagnoses may be incorrect. Treatment adherence may not have been good. Therefore, admission to a correctional setting is an opportunity to improve a treatment regime and reduce potential harm. However, there may also be many possible reasons why a community prescription is the way it is. (It is not usually the case that medication is sought in the community just so when the prisoner arrives in prison it can be trafficked). The treatment may be a result of several years of careful and thoughtful consideration and incremental refinement. Even if one of these possibilities is the case, when changes are made there is usually no contact with the community treatment provider to establish the reason. There is usually no consultation with the patient either.

An alternative explanation provided for altering medication on admission was that some medication prescribed in the community might be trafficable within the prison. As potentially any medication can be given from one prisoner to another, and can be trafficked, in this context trafficable means medication which might have some value to prisoners and can be traded between them for any number of reasons. Some of this type of medication, for example some anti-psychotic treatment such as quetiapine, has been legitimately prescribed in the community according to good practice guidelines: it would be its immediate rather than gradual withdrawal that is not. Prescribing decisions need to be made on an individual case by case basis and not the generic stopping of specific drugs.

Recommendation 34

All medication changes made at the point of admission (and thereafter) should be discussed with the patient before they are made. Until then, drugs prescribed in the community should be continued unless contraindicated; wherever possible community health providers should be contacted for treatment information, and proposed changes discussed.

It seems that the CPHS is extremely concerned with the notion of trafficking of medication within the prison. Although of course it is part of good practice to ensure that the right medication gets to the right person at the right time at the right dose, once medication is administered to the right person, any number of mechanisms can be adopted by prisoners to subvert its subsequent destination (for example, 'palming' or 'cheeking'), making it look like the medication has been swallowed when it hasn't. Many mechanisms have been adopted to ensure medication is not handed on, and many highly trafficable substances can be dispensed safely (such as methadone). For example, most medication administration is directly observed and checked by a nurse and a correctional officer: the taking of the medication is documented. This standard is not usually met in the community, only in a hospital. It does assist in ensuring adherence, but does also guard against trafficking.

Potential trafficability should not distract health professionals from prescribing what they see as being in the best interest of their patients or prevent the treatment of legitimate medical and mental disorders. If it becomes a repeated problem for some patients, then of course alternatives can be discussed and trialled, but clinical discussions are needed. Trafficking substances is primarily a matter for the correctional authorities (for example, the training in the detection of cheeking, palming or other techniques). Of course, clinicians can help by avoiding inappropriate prescribing, making changes with caution, where appropriate reducing prescribing of medications at higher risk of being abuse or diversion, using the lowest effective dose, and treating any substance misuse disorders in the prison (which may reduce demands for diverted medication).

It may assist if referral is made to national and international guidelines for prescribing in correctional settings, particularly for controlled substances, for example Safer Prescribing in Prisons.[45]

[45] Bicknell (2019)

Medication charts

The medication prescribed in prison is written on paper medication charts. These are highly problematic for multiple reasons. They are often illegible, require rewrites, changes made require new scripts, multiple charts can exist at the same time in different places, it can be very difficult to keep track of what is being prescribed and when. Prisoners often move quickly around the system, for example from a prison to hospital, back to prison, to court then to another prison before being returned. Medication charts don't usually follow prisoners. Their possessions are more often more closely tracked than medication is. If medication is required throughout, practitioners who haven't seen that person before often don't know what has been prescribed before. Medication charts can be easily misplaced. At the conclusion of the treatment the charts have to be filed and archived, and take up a huge volume of space, and cause a potential fire hazard. The potential for error in this system is enormous. It is sometimes a wonder how prisoners ever get the right treatment.

Recommendation 35

Electronic prescribing is established.

Recommendation 36

Historical paper medication charts should be moved and stored off site in a central location.

Pharmacy

Pharmacy staff consist of three pharmacists and three technicians who together service all the adult prisons and AYDC.

The pharmacy is located in the health centre of RPC. It dispenses prescribed medication into Webster packs made up for each prisoner. The process is as streamlined as it could be under the current arrangements. Any delays or gaps in medication administration are not caused by pharmacy delays, but rather systemic issues relating to the system of medication administration. Overall this is, however, extremely time and resource intensive, not fail safe or contemporary.

The medication itself is sourced by the pharmacy at RHH so the medicines are largely the same as those available to community patients.

Medication in Webster packs is then distributed to the health centres of each prison on a daily basis.

Webster packs

Medications for prisoners are prepared in Webster packs by a centralised pharmacy once a prescription is received. These packs contain all the medication for that individual, with separate blisters for different times of each day. This process has been adopted because it is deemed to be much the safest, efficient and cost effective way of distributing medicines within prisons. However, it is not always patient-centred, can be inflexible, cannot accommodate titration or changes of dose quickly, creates considerable delays (sometimes many days) in patients receiving treatment after initial prescription, changes in dose, or after reception into the prison. These issues are especially relevant to the treatment of mental illness, which often requires rapid changes of medication regime in response to tolerance, side effects, changes in symptomatology and efficacy. The doses therefore cannot be titrated or altered according to clinical need. Webster packs cannot be used for liquid formulations.

Another reason given for the use of blister packs is that often the only way of telling whether a patient has received medication is whether the medication is present in the Webster pack. This is however not equivalent to making a record at the time. Medication may leave the Webster pack and may not be taken by the patient. It could be thrown on the floor or surreptitiously thrown away or given to someone else.

Imprest

Each prison has a small inventory of medication, called an imprest, that it keeps in stock so that if it is prescribed by a doctor locally, it can be administered without having to wait for the pharmacy (which may be in a different facility) to make up Webster packs and thereby minimise any delays. The list of medication available in the imprest appears to vary site to site, and to some extent depends upon the resourcefulness of the individual nursing staff who work there. Whilst kindly and very understandable, this way of operating is hit and miss, dependent on site, staff and what is available, and should be unnecessary if the system worked as well as required. One reason for the discrepancy in the size of the imprest available in the reception prisons is that one (LRP) is not dispensed by a pharmacist, and so it is of concern that these medications may be being administered contrary to regulation. A larger imprest may be required in reception prisons because many prisoners do not have their own supply of medication on them when they are arrested and many of these medications may need to be continued without disruption. The delay in dispensing medication after reception can cause significant risk to the patient, as

withdrawal from some medication, for example some anti-depressants, can lead to discontinuation syndromes and elevation of risk.

Recommendation 37

The policy and practice regarding drug availability in imprests in various sites should be reviewed and standardised and brought into accordance with Tasmanian pharmaceutical regulations. If pharmacy input is required at Launceston Reception Prison, this should be organised.

Recommendation 38

Commonly required medication should be available in imprests to avoid gaps in medication administration.

Medication Administration

Health staff administer medication to prisoners. Medication rounds usually occur twice per day. Some medication is not administered according to manufacturers' recommendations or existing prescribing guidelines. For example, evening doses are often dispensed at 4:00 pm, not necessarily for the benefit of the patient but for the convenience of the prison regime. In some cases this may interfere with the pharmacodynamics of the drug, compromise the effectiveness of the treatment, produce disturbances in patient's sleep-wake cycle and may compromise patient safety. If prisoners are given night-time sedating drugs, they therefore have to be taken at 4:00 pm which induces sleepiness for the evening meal and muster, and the individual then awakes later during the evening and is unable to sleep at night. This is nonsensical. It was a source of considerable complaint from prisoners. Some conditions require medication to be dispensed after 4:00 pm.

During the inspection, both TPS and CPHS were asked why this was the case and why medication could not be safely administered later on in the evening where required, say at 8:00 or 9:00 pm. TPS said that it would be possible from its point of view, and it would welcome such a move. CPHS agreed that there was in fact no reason why a medication round could not occur later: it had the staff available at that

time to facilitate this. It seems astonishing that this has not already occurred given the seeming agreement that it would be preferable for all.

Recommendation 39

Evening medication rounds should be established particularly for sedating or psychotropic medication.

Medication security

It is a fundamental principle that medication should be administered to the right patient at the right time at the right doses and recorded as having been given by the nurses and cross checked by a colleague with the authority to do so. In prison there are several challenges to this process. Some of these have been mentioned above.

Prisoner identification is required to ensure the name of the prisoner receiving the medication matches that on the script and the Webster pack. This may not be as easy as it first appears with similar named prisoners sometimes potentially trying to take advantage of that fact. Secondly medication is occasionally administered through the hatch of a cell. Where this is a single cell this should not present an issue, but where there is more than one prisoner to a cell, it can be difficult to ensure the medication is given and taken by the right prisoner.

The next issue is that occasionally prisoners will sometimes seek to keep the medication administered to them in some form and to hand it on to another. This may be due to coercion because that medication is seen as desirable or has currency, or to sell for gain. Some say they retain the medication for use ‘later’. The secretion of medication in prison has a long tradition, and the mechanisms of doing so are myriad, complicated and often ingenious.

Prevention requires a number of strategies, including minimising supply of ‘desirable’ or ‘trafficable’ medication, as discussed above, providing medication in Webster packs, providing it in non- or less- trafficable forms, checking at the point of administration, and punitive responses if it is discovered. The main strategy adopted by CPHS appears to be the first. The problem with this approach is that in preventing the use of any substance deemed at all ‘trafficable’ means that the use of otherwise very useful therapeutic and efficacious drugs is curtailed for the vast majority of those with genuine conditions who need that drug, with the prescription of less effective medication perhaps even contrary to clinical practice guidelines. The second approach of using Webster packs is widely adopted and is sensible. The

third approach is contingent on the pharmacokinetics of the individual drugs, some of which will not be effective and absorbed in the right way if the preparation is altered (e.g. by crushing or dissolving or turning into liquid or gel form). The fourth approach requires vigilance of custodial officers to observe administration, check mouths are empty, use secure administration areas, and keep prisoners under observation for a few minutes after administration. This can be time consuming and difficult, particularly if there are large numbers of prisoners who need to be kept separate. The last strategy of punitive responses includes charging with specific offences and findings of secretion being met with specific consequences. Many of these usually include withdrawal of the medication concerned. This however seems to be a response which denies the need for which the medication was originally prescribed and over which the patient may have little control. The punitive denial of treatment goes against some fundamental principles and should therefore be avoided. Of course, if a less desirable or trafficable alternative can be prescribed which is equally effective, that should be considered.

Recommendation 40

A multi-agency review of medication security should be undertaken with a view to enhancing it where possible, so reducing the potential for trafficking of medication and therefore increasing the use of medication that is therapeutically useful but deemed trafficable.

The recording of whether a prisoner has taken medication is undertaken by the administering nurse, and to prevent medication errors is usually cross checked and signed off by a counter signatory. This has involved correctional staff who are often unsure of the exact responsibilities which go with such counter signatures, and are untrained in looking for potential issues with medication administration.

On person medication

Except in trusted prisoners in low security, perhaps preparing for release, medication is not usually permitted to be kept on their person or in cells for self-administration. The reason for this is that there is concern that prisoners may not take their medication or others might take it. However, in some cases self-administration might allow additional patient choice, save time for the patient if the medication line is too long (or for the practitioner), reduce stigmatisation, or reduce inconvenience if it has to be given at an inconvenient time (during work for example). If prisoners don't wish to take medication, they should be free not to take it. This is the situation which

would largely prevail in the community, or at home. The majority of medication has a low potential for abuse. There are clearly some medications which requires more control and supervision, for example those which could be trafficked, or stockpiled and are dangerous if used in overdose such as paracetamol (see below) or psychotropic medication.

Recommendation 41

The use of on-person medication be reviewed.

Across the counter medication such as simple analgesia

The lack of readily available cross counter medication such as simple analgesics for pain or headache sometimes causes significant frustration, particularly during lockdowns, or during weekends when the health centre may not be available. It should be possible for prisoners to access such simple remedies at the discretion of unit staff when appropriate. An evening headache for example requires treatment with simple analgesics, but under the current regime prisoners may have no access to medication for many hours.

Recommendation 42

Over the counter medication should be more readily available in the units. Tasmania Prison Service and Correctional Primary Health Services should work to establish an effective policy to implement this.

Recommendation 43

Correctional Primary Health Services consider creating a list of medication that nurses across the prisons are permitted to dispense both with, and without, a prescription.

Use of medication for mental health issues

Despite the multiple problems and considerable resources needed relating to medication dispensing, the use of medication appears to be the mainstay of treatment for mental health disorders, even when other interventions (for example, therapy in various forms) may be preferable. Indeed, for many cases medication appears to be the only therapeutic intervention offered, and as such does not accord with evidenced based practice, and is far removed from equivalence of care provided in the community.[46] Treatment modalities such as cognitive behavioural, interpersonal and supportive psychotherapy should be provided. Until more alternatives to medication are provided, the service will never achieve its aim of delivering equivalent care. Medication appears sometimes to be used even as a cure for distress, in the relative absence of psychological treatment or counselling.

Post release prescribing

When prisoners are released, the change of location may cause a disruption to their supply of medication until they have established themselves back into their community, or found a new doctor and a pharmacist able to dispense required medication. For this reason, when prisoners leave it is usual practice for them to be given a few days medication to take with them to last until the community supply can be re-established. If released unexpectedly by a court, for example on bail, the medication may not have been sent along with them, so this is not possible. This has numerous undesirable consequences. It should be possible that prescription charts and Webster packs even if half used could be packed up (alongside their possessions and other key identifying documents and warrants) to go along with them to court as a matter of routine. They can then be brought back as necessary, or sent with them to alternative facility if that is the outcome, or be taken into the community. More than one or two days' worth of medication (useless if released say on a Friday) should be provided. The pharmacist thought this would be easily achievable.

Of course, good practice also dictates that care is passed onto to the identified community provider to ensure continuity of care is preserved wherever possible.

[46] Harrison (2004)

Recommendation 44

Medication be sent with prisoners to court with personal belongings as a matter of routine.

Recommendation 45

The post release medication practices should be reviewed and at least one week's medication should be sent with prisoners who are attending court or who are being released.

Oral care

Dental care provided within Tasmanian Prisons was described variously from dreadful to amazing. This latter description the inspectors found to be somewhat aspirational, not necessarily because of the quality of care provided when it is provided, but the quantity available, which is wholly inadequate to meet the considerable demand and even more considerable degree of pathology that is present.

Dental care is available under the direction and supervision of a dentist licensed to practice. Dental care provided in many ways reflects that available in the general community: that is to say it is woefully inadequate, and access to screening, to treatment even for urgent or painful conditions is not timely. Often delays of many months occur. Access to non-urgent care is glacial, and access to preventative dental care non-existent. The dental service provided is considered as an extraction only service. There is no oral screening or routine dental examination on reception, and there is no oral hygienist provided. Routine oral treatment is not available.

Over recent years the service has not improved. Even when individuals agree to pay for dentures or for other procedures on a private basis (which is permitted), this takes many months. If prisoners are required to pay up to $600 to access private dental care, this disadvantages those without access to such significant funds. Some prisoners told us that they resorted to pulling their own or each other's teeth out.

Dental care is completely denied to those who have been in custody for less than six months or those on remand, even though this period can be extended. The only possible rationale for this is rationing, but to do so on this basis makes no sense as it is clearly not based on dental needs. Dental needs are therefore not met and the dental needs of the many waiting or triaged out of the waiting list are severely neglected. The service is therefore not delivered according to individual need. As a component of healthcare, dental services seem to be relatively ignored.

Recommendation 46

The criteria for access to dental care should be reviewed to include all patients, both sentenced and remandees, who meet the clinical criteria for care and they should be screened against these criteria by staff trained in dental triage.

When oral care is so scarce, it can have an adverse effect on an individual's wellbeing. Constant pain leads to short- and long-term mood changes, irritability, lack of tolerance, and this can have an effect on the morale of prisoners and on day to day behaviour.

Methamphetamine is one of the drugs most commonly misused by people in the Tasmanian community. Due to its effects, it can lead to severe gum disease, dental cavities and tooth decay. Many teeth are blackened, rotting, crumbling or falling apart. It is often caused by dry mouth and long periods of very poor oral hygiene. The methamphetamine itself is acidic. Often carbonated drinks are craved in significant volumes which compounds the problem. Teeth are often ground or clenched. The pain-relieving effects of the drug mean that whilst using methamphetamine, many users do not appreciate the adverse effects that the methamphetamine is having on their teeth, and the pain is masked, but in withdrawal after reception into custody this rapidly becomes all too apparent and the pain can be severe. Pain relief is often withheld, and requests dismissed as drug seeking.

The inspection team discussed many issues regarding the existing dental service with the attending dentist. He attends the prisons on a weekly basis, alternating between RPC and RBP. There is some flexibility, so if one of the prisons (usually RPC) is in lockdown and he cannot access prisoners (meaning their long awaited appointments are cancelled) - which happens increasingly often - he can attend the other site to conduct a clinic. In RBP the escorting requirements are much less onerous so the clinic runs much more smoothly. There are no requirements to keep prisoners (of different security categories) segregated from each other.

The dentist said that he usually sees between four and six patients per day. The people the dentist sees and treats are decided by CPHS staff. These are members of the nursing team who assess and triage all requests for dental work. We were informed that these nurses have often had no training and have no expertise in dentistry. It is not known how they would know how to triage cases appropriately. He thought that most cases of dental infection, swelling, 'raging' toothache or trauma would be prioritised but could not guarantee this. The dentist recognised that perhaps because the triaging system is so efficient and he is protected from all the requests for treatment that are made, he really has little understanding of the extent of the real demand in the prison population.

The dentist did state that dental care in the community is also scarce. He did therefore feel able to defend the current position. However, just because the standard of correctional healthcare care may be the same as provided in the community, which by reports is poor, it should not limit the standard available in the prison. He also stated that if someone in the community had been on the waiting list for dental treatment for a period and was then placed into custody, they would lose their place in the queue and would have to go to the back of the queue for the dental waiting list in prison, and vice-versa. On the face of it this seems nonsensical, unjust, and punitive. A cross referring between the two waiting lists would easily solve the problem.

Recommendation 47

Correctional Primary Health Services should work with Oral Health Services to review and amalgamate the correctional and community waiting list to ensure people are not disadvantaged regarding their waiting times for dental treatment by virtue of changes to their custodial or legal status.

As everywhere else in the healthcare centre, staffing availability on the day is the main determinant of whether a clinic proceeds. The COVID pandemic had an influence, and correctional staff shortages and lockdowns of course affected clinics. However, the rate determining step in limiting the numbers of people seen appears to be the availability of the dentist (or the amount of time allocated to corrections). There is enough serious pathology to easily justify at least another day per week (a doubling of current input), if not an additional two days per week. A business case should be developed by CPHS without delay for the doubling of dental input. The argument will be helped by the huge public health contribution this will make to dental health of historically poor users of services.

Recommendation 48

Dentistry services at the prison need to be doubled without delay.

Allied health care

Podiatry is provided but clinics are sporadic and there is a substantial waiting list. Access to an optician is also restricted. The physiotherapist attends once per month. This does not reflect demand.

Recommendation 49

Correctional Primary Health Services to review input provided by allied health professionals and business cases prepared to increase input to meet demand where necessary.

Emergency services

When there is a medical emergency within RPC, MHWP, or RBP, an alert is put out over the radio. The emergency response nurse returns to the health centre and an escorting officer meets them there as soon as possible. They collect the emergency bag, and carry it to the location of the emergency and administer the aid required. This process can take a few minutes, and so in some cases it may take between five and ten minutes for the nurse to arrive. We were told that the emergency bag is bulky and can be difficult to carry.

Segregated prisoners

There is no requirement for prisoners who are in lockdown to be medically reviewed, even if segregation has been prolonged (see section on lockdown for recommendations regarding this).

Inpatient Unit

Infrastructure

The Inpatient Unit has recently had a much-needed refurbishment. This is just as well because the area which used to act as the Inpatients Unit is grim. It is dark and has a foreboding dungeon-like and distinctly un-therapeutic décor. If it is to be continued to be used, it too needs refurbishment. That this area can still be used occasionally in preference for the newer, brighter, more airy and therapeutic spaces a few yards away is nonsensical. Unfortunately, the inadequacy of the newly installed infrastructure rapidly came to light when a prisoner easily ripped a door off its hinges (several months on it has not been refitted), and another punched a hole through the flimsy plasterboard of the new walls.

Recommendation 50

Upgrade and mend the broken fittings in the Inpatients Unit.

Recommendation 51

Refurbish the areas of the old Inpatients Unit.

Staffing

The staffing and use to which the Inpatients Unit is put require a thorough review. The Inpatients Unit is located within the health centre and a distance from other units. Some patients stated that whilst there, they felt relatively isolated, sometimes for long periods. There was little to do, except for a sparse day room to visit. There is a small garden area for access to the open air but not all prisoners get daily access to this area. We received reports of some prisoners getting their one hour out of their inpatient cell in another room, which has no access to fresh air. The very small outdoor area connected to this room had a sign indicating prisoners were not permitted to access it. Moving someone from one locked room to another does not meet the requirements of access to open air in s29(1) of the *Corrections Act 1997* and international law.

Some thought that they did not have sufficient nursing care. There is at least one carer in the Inpatients Unit during the day, but often no nursing staff. The Unit is not routinely manned at night by correctional officers. TPS agreed that the Inpatients Unit is the first area of the prison to be placed in lockdown if the numbers of correctional officers were short, so that staff there can be redeployed to other, more populated areas, to prevent lockdowns there.

Recommendation 52

Review Tasmania Prison Service and Correctional Primary Health Services staffing of the Inpatients Unit, particularly the reallocation of Tasmania Prison Service staff to other areas during lockdowns.

Use of the Inpatients Unit

Several staff told us they believed that Inpatients was underused. The current patients had a mixture of conditions, including a person with a terminal condition receiving palliative care, and another requiring long term care. We were told it was not possible to use the Inpatients Unit for intravenous infusions, for example for antibiotics, or for other relatively minor or straightforward medical procedures such as suturing or dressings. Staff thought this might be due to a licensing issue but according to senior CPHS staff, it is primarily because staff are not accredited or have not been sufficiently trained or are not sufficiently skilled in the delivery of such procedures. This suggests that some health staff working at the prison have not kept up with training, and could receive such training to undertake these and other procedures in a safe manner, enhancing the use of the Inpatients Unit. This needs to be addressed as a matter of urgency: it would result in a more skilled workforce, greater access to care at the prison and a reduction in the number of escorts to hospital required (see below). This would mean that those escorts taking place would be confined to procedures and consultations that could not be undertaken at the prison.

Recommendation 53

Review the use of the Inpatients Unit, the medical procedures that could and should be undertaken there, and deliver appropriate training to staff as soon as practicable to reduce the number of escorts to hospital.

If Inpatients is to be used for more complex medical procedures, the security of the rooms will also need review. Some patients under these circumstances will require immediate access by health staff: it would not be medically acceptable for staff to wait outside a locked room for custodial officers with the necessary security clearance and authority and keys to be found from elsewhere in the prison to open rooms in an emergency situation, or even just to change a drip.

Recommendation 54

Review security needs to Inpatients Unit to allow immediate medical access to all rooms.

It would assist if a list of minor procedures that could and should be undertaken at the prison and those which should be reserved for the hospital were to be agreed between TPS, CPHS, DoH and RHH. It would assist in planning the additional training required, the training to occur and staff to develop the competencies and confidence to provide such services. It would also identify the necessary additional equipment required and kick-start the process of purchasing and installing it. This would be relatively easily achieved with significant benefit to all parties. It is not clear why this has not already been delivered, particularly as many nurses have not been working to capacity due to lockdowns that have been imposed and the many prisoners not attending for appointments. It does seem bizarre to have invested in physical refurbishment but not to have maximised its use because of inadequate training, particularly when access to care at RHH has been so significantly reduced.

Clinical spaces

The new clinic situated in the SRC is well designed, with each of the two clinical rooms having dual egress and good line of sight. It is disappointing that only two rooms were made available. The entire clinic had to be cleared for one prisoner who presented a security risk, and was on a three man unlock. The running of the clinic is dependent on there being sufficient custodial staff to facilitate it. If these are not available, the clinic is not opened and access to medical practitioners denied.

The clinical room at LRP was small and cramped, with little room for an accompanying officer if one was required. It has only a single entry point.

The Crisis Support Unit (used to house prisoners at risk of self-harm) in RPC was physically grim and is the most untherapeutic space I have encountered in many years. It would be a difficult task indeed to support or care for anybody in those

circumstances. The prison superintendent told us this was their least liked area of the prison. It is easy to see why. TPS needs to change it.

Recommendation 55

Review the use, function and infrastructure of the Crisis Support Unit to ensure it is a therapeutic space.

Diagnostic services

Bloods and other pathological samples are sent daily to RHH for processing and analysis. There are no X-rays or other diagnostic investigations available at the prison.

Hospital and specialist care

The total number of escorts available on any day is two or three. It used to be eight, but this was reduced in approximately September 2022. The effect this has had on healthcare has been profound. Included in this number are all escorts for routine specialist appointments, acute or emergency care, investigations or for any other reason. This means that many long-awaited for appointments have to be cancelled often at short notice, and this delays treatments significantly.

Recommendation 56

Increase number of medical escorts to hospital back to eight without delay. This will take some work regarding resourcing, but it should be a priority.

There are a range of transports available for such escorts, allocated according to security rating, circumstances and availability. Some of these options are unsuitable for the elderly, frail or prisoners with disabilities, as some of the buses do not have appropriate access. One has wheelchair access. Where transport with additional features to accommodate these needs is required, it is indicated by health staff, allowing appropriate allocation of transport. We heard one anecdotal account of a

prisoner being unable to exit the transport at RHH without assistance. The transport officers stated it was not their duty to assist and the orderlies at the hospital were equally unable to assist, so the patient had to return to the prison unseen.

Risk assessments are undertaken prior to each escort. Presumably this covers welfare of the patient and safety and security concerns, and includes what restraints, if any, are required. We were assured that prisoners' welfare is monitored during the course of the journey.

There is particular sensitivity regarding such escorts at present due to the recent high profile escape of a patient from custody whilst he was receiving care at RHH. Alas, whilst at large, he was killed. Since then, a security protocol has been published for all high and medium security prisoners which removes all discretion in the use of restraints, and requires use of handcuffs even when some patients are too unwell to walk. We saw several examples in minimum security where handcuffs had been used and caused bruising and bleeding, particularly in frail and or dying elderly men. Officers are also required to be very close to prisoners, meaning that it is very difficult to ensure prisoners' confidentiality.

But practical solutions to overcome some of these issues are possible. We visited the emergency department at the RHH which is planning a major refurbishment. A secure area is planned within the designs, but to ensure it is optimally effective and could be used for prisoners, it would help if senior CPHS and TPS staff could be consulted at this design phase to ensure the necessary features to optimise security and safety for prisoners could be incorporated.

Recommendation 57

Correctional Primary Health Services and Tasmania Prison Service work with the Royal Hobart Hospital to plan the implementation of secure areas in the refurbished Emergency Department so they can be used by prisoners and escorting staff.

It would help if the MOU between TPS and RHH, signed in 2013, is revised so all parties could understand what is expected, who is responsible for what during visits by prisoners (for example whether a secure area should be used, where and when the patient is seen, how long personnel will have to wait), security, records, medical interventions, clinical decision making (e.g. whether the patient remains in hospital or is returned to prison), how to maintain confidentiality, use of a private entrance etc. It is understood that sometimes patients from the HRP are simply walked across the road to ED by staff. Two inspection officers shadowed a medical escort, with the

prisoner's consent, where this occurred for a medical appointment. This seems neither very secure nor private, with little dignity for prisoner nor staff, although practically sometimes probably expeditious.

Recommendation 58

Develop a Memorandum of Understanding with the Royal Hobart Hospital and the Launceston General Hospital regarding mutual expectations and ways of working with prisoners to ensure their safety and welfare as well as that of the public. The Memorandum of Understanding with the Royal Hobart Hospital and the Launceston General Hospital should also consider introducing regular visits of specialists to the prisons.

It has been recognised that a dedicated team to facilitate these escorts would be ideal, rather than using officers often allocated to other duties which then cannot get completed, or using staff on overtime. At the very least there needs to be a dedicated team and dedicated transport options. Many jurisdictions which have had difficulty in supplying sufficient officers to operate an effective escort or travel system for prisoners have outsourced these services under contract to an external provider. The provision of these services is often not seen as core business of corrective service personnel. Examples of good practice should be sought and the outsourcing of such services to a specialist provider considered. The staff questioned about this were concerned about the extent to which this would erode the availability of officer overtime, but these same officers are not available to keep the prison fully operating.

Recommendation 59

Review arrangements regarding escorts. Consider outsourcing of the transport function to an external provider while Tasmania Prison Service is unable to staff the function to sufficient levels.

Sometimes there are long delays at the local emergency department which can get very busy. Officers have to wait alongside their prisoner patients, and it can be

several hours before being seen. If the requirement is for the person to stay in hospital, the escort has to remain for the duration of their hospital stay.

The list of expected hospital visits and need for escorts is drawn up week by week. TPS stated that often this list does not get passed to them until late on Friday for the following week, making the logistics of the transport and the escorting staff difficult to organise. Where insufficient staff are available this can lead to cancellation. Given this list is theoretically available earlier in the week as all but emergency appointments at the hospital are planned, it should be possible for the CPHS staff to get the list to TPS earlier in the week. TPS have indicated since this inspection that the escort list in now supplied to them on Thursday, making planning easier.

Recommendation 60

Correctional Primary Health Services to liaise with Tasmania Prison Service staff in good time regarding escorts required.

At least three ways of reducing the need for hospital escorts have been identified. The first is to increase the use of the Inpatients Unit (discussed above). The second would be to enhance the number of specialists visiting the prison from RHH. TPS would have to let them in and facilitate the clinics so they could see patients. The third would be to enhance the use of videoconferencing technology. Since COVID-19 the possibilities for the use of videoconferencing technology have expanded. Facilities are available at both the prison and the hospital, so why this isn't being routinely used is a mystery. CPHS should explore this option.

Recommendation 61

Increase use of video-conferencing and telehealth for healthcare, wherever possible, with outpatient clinics to minimise escorts required.

Special needs and services

Women

Women's healthcare was reviewed and appeared to be exceptional. A wide variety of monitoring, investigations and treatments were offered for the full range of general medical conditions and for issues specifically relating to women. There was significant health promotion activity. Of note, in general healthcare delivery was prompt and thorough for this group.

We were informed that there was insufficient information and support provided about menopause.

Recommendation 62

Review the level of information and support required regarding the management of menopause and related symptoms.

A Volunteers for Change program was a good initiative, enabling the community of female prisoners to make recommendations to improve health and wellbeing. This initiative was going to be rolled out in RPC medium security next, and should be expanded to the rest of the male estate, because ideas for improvement are generated locally and can be acted upon. The program should be incorporated into the clinical governance program.

Recommendation 63

Incorporate the Volunteers for Change program into the male estate and into the Correctional Primary Health Services clinical governance program.

There was one pregnant person in prison in Tasmania. Her date of release pre-dates the expected date of delivery. There are pleasant and adequate facilities for a mother and young child to stay in MHWP if this necessity arose. There are policies in place to ensure pregnant women beyond a certain gestation are not shackled

when attending external health appointments. Access to general practitioner care is good.

Mental health input for women appeared to be improving but only one day per fortnight was offered. There was next to no AOD rehabilitation available to women. It was noted by the inspection team that there was no peer support service available to women.

Recommendation 64

Tasmania Prison Service reintroduce the peer support service into Mary Hutchinson Women's Prison.

Recommendation 65

Develop Alcohol and Other Drug rehabilitation services for women to reflect their level of need.

Recommendation 66

Mental health input to the Mary Hutchinson Women's Prison may require review. An audit of need should be conducted and the input provided should reflect the level of assessed need.

Escorts for female prisoners tended to be provided by female officers.

Youth

The Ashley Youth Detention Centre (AYDC) was visited. On the day of inspection it had nine detainees with capacity for 52. Aboriginal and Torres Strait Islander people are significantly over-represented in the population of detainees. Most detainees are troubled and have numerous complex psychosocial issues. Often these include traumatic histories, and AOD issues. ADHD and eating disorders are common in this

population. The majority of health needs therefore fall into the psychiatric and psychosocial sphere rather than physical healthcare, and this was addressed in detail during the recent inspection of mental health services.[47]

The mental health input comes from a visiting child psychiatrist who attends one day a month (0.05 FTE) and from a visiting Australian Childhood Foundation therapeutic services support worker who attends once a week (0.2 FTE). Services from headspace have been requested but seem to be unavailable. A number of programs are offered. The care model is trauma informed and it is an individual needs-based service. A consistent approach is provided. We were told that a conflict resolution program was not available. A welfare check is undertaken on every detainee every 20 minutes. We were informed that the centre was trying to develop a therapeutic collaborative care team approach that involves cross agency support and planning for residents.

Drugs enter the unit occasionally. There is significant methamphetamine use in the community. There is little AOD work undertaken in the centre for the principal reason that most detainees are in the pre-contemplative phase of use and most reject any offer of services. Services however are available once per week. Many detainees request treatment from the psychiatrist with quetiapine, a sedative and anti-psychotic drug, and we were told that detainees are known to tell each other what to say to the doctor in order to maximise the possibility of it being prescribed.

Confidentiality is important but given the number of agencies involved, in any one case it can be a challenge to maintain. Discharge planning involving many agencies is usually required. Healthcare identifies the treatment needs and provides support. We were informed that the treating psychiatrist also provides psychiatric reports to courts due to a shortage of psychiatrists in Tasmania with equivalent forensic experience. We were advised that they are required to provide court reports under their TAZREACH contract, a program funded by the federal government to provide health services to rural, remote and regional areas that otherwise wouldn't be available. This is an acceptable practice, but care needs to be taken lest any information obtained through a therapeutic encounter which might be deemed confidential is later disclosed without informed consent to third parties such as the court.

From a physical health perspective, a nurse is in attendance every day, and it is considered to be a nurse led service. A GP visits once per week. New detainees are screened by the doctor during the doctor's next visit. This includes a risk assessment of suicide and self-harm. We were assured, however, that if a doctor was required prior to the scheduled visit this would be arranged. There are weekly observations made, including STI tests where required. Routine blood tests are undertaken annually. The service prided itself on a superior level of healthcare input than is commonly provided in the community. This includes dentistry. If referrals to hospital

[47] Norris (2022)

are required these are made, or can be made earlier than the initial screen if urgently required. The service has a close working relationship with Launceston General Hospital (LGH).

Like the Tasmanian Prison Service, AYDC is suffering from the effects of low staffing levels. This recently prompted recruitment from other states, and several youth workers joined the service from the Northern Territory.

It was noted throughout our visit that the acoustic conditions in some of the units and in the gym made hearing difficult. Studies in school environments have found that high levels of background noise have a negative effect on staff wellbeing and that young people find it difficult to understand staff and feel more anxious and depressed.[48] High levels of background noise also make communication difficult, and this can lead to increased frustration in both staff and young people.[49] Stress and frustration can lead to heightened behaviour from young people, such as refusing to attend education or programs, property damage or violence. Sound-absorbing materials can create calming acoustics in youth correctional facilities, and therefore reduce the effects of high levels of background noise.

Recommendation 67

Ashley Youth Detention Centre engage an acoustic consultant to review the acoustic conditions in units and other areas, such as the gym, and implement the advice as appropriate to improve and create more calming acoustic conditions.

Healthcare for Aboriginal and Torres Strait Islander people

At any one time about 20% of the prisoner population are Aboriginal or Torres Strait Islander. There are, however, no specialist services offered to, designed for, or dedicated to meet the needs of, Aboriginal and Torres Strait Islander people. There are currently no staffed Aboriginal or Torres Strait Islander identified positions in TPS or healthcare. This needs to be addressed.

[48] Recalde (2021)
[49] Karthaus, R (2017)

Recommendation 68

Tasmania Prison Service and Correctional Primary Health Services should conduct a recruitment drive targeted towards Aboriginal and Torres Strait Islander people.

Recommendation 69

Correctional Primary Health Services should ensure that culturally appropriate care is provided to people from Aboriginal and Torres Strait Islander communities.

Mental healthcare

Mental health was reviewed in 2022 during another inspection, so this inspection did not cover this area of healthcare delivery. A number of issues were however noted.

The majority of mental healthcare occurs in primary healthcare settings in the community, and this is also the case in prison. Frequently occurring disorders such as depression and anxiety disorders are managed through primary care, and this is appropriate. Secondary mental health is dedicated to the assessment and management of less commonly occurring and complex disorders. The link between primary health and secondary mental healthcare services is therefore important. Collaborative care between the services appeared to be good, and referrals between these services occur when required.

The Mental Health team in CPHS consists of 0.9 FTE, comprising one 0.8 FTE psychiatrist in the male prisons and one 0.1 FTE psychiatrist in MHWP and an additional 0.3 FTE of a psychiatric registrar. There is no psychiatric cover provided to LRP or HRP. There is 1.0 FTE Psychiatric Liaison Nurse (PLN) position, which is rostered daily. There are plans to considerably expand the number of mental health professionals in CPHS arising from the Prisoner Mental Health Taskforce.

Where hospitalisation of a mentally unwell person is required, a hospital bed can usually be provided within a few days in the Wilfred Lopes Centre. This secure mental health unit is able to provide care for two or three prisoners at once. We were informed that seclusion rates there are very low, and there is a high staff ratio. It was not possible for the inspection team to visit this unit and it does not fall within its jurisdiction.

In 2016 a community homicide by a mentally disordered newly released prisoner prompted an inquiry, but all of the recommendations have not yet been implemented. Post release care for mentally ill prisoners can be very challenging to arrange because community mental health teams are usually inundated. No case management transitional care can usually be provided. The Community Forensic Mental Health Team undertake case management for forensic cases, but because this is a restricted service many community mental health teams manage high risk people themselves.

Recommendation 70

The need for transitional case management needs to be reviewed given the impact it can have on recidivism. Transitional case manager positions should be created and a manager appointed.

Suicide prevention programme

There is a suicide prevention program which appears to contain the necessary elements for a comprehensive program within TPS. The usual components of a suicide prevention program include:[50]

- Training for staff on verbal and behaviour cues indicating suicide risk and appropriate response
- Identification of potentially suicidal inmates
- Referral to mental health providers or facilities
- Evaluation by a qualified mental health professional
- Accommodation in a safe area of the institution
- Treatment to address the cause of or the reasons for suicidal thoughts
- Monitoring procedures that permit regular documented supervision
- Communication procedures between health care and corrections personnel
- Intervention procedures addressing how to handle a suicide attempt in progress
- Notification procedures to ensure appropriate correctional authorities, outside authorities and family are contacted
- Reporting procedures for documenting attempted or completed suicides
- Review of suicide and serious attempts by health care and administrative staff
- Critical incident debriefing offered to affected personnel and inmates in the event of a completed suicide

The program was not fully evaluated during this inspection as it more fully comes under the remit of the mental health inspection which occurred in 2022. However,

[50] National Commission on Correctional Health Care (2008)

various observations were made. At the time of the inspection, TPS employed one psychologist despite ongoing attempts to recruit to the remaining four vacant psychologist positions. There is only one mental health nurse rostered on each day. Providing input to the program appears to be more or less the sole purpose of the therapeutic team. Approximately 20 assessments are required every day. The risk assessments required in the program could not of themselves be considered therapeutic. Not a substantial amount of therapy can therefore be provided.

Disability and aids to impairment

Some specific issues with regards to disability were raised during the course of the inspection:

- Wheelchair access across the prison appeared to be good. No problems were reported by a prisoner who uses a wheelchair with the exception of access to parts of the yard in SRC. He used his own wheelchair without difficulty. He had a say in who his personal carer is. He did not feel any sense of discrimination and did not experience any abuse. His experience of healthcare was good.
- As above, we did hear unconfirmed and anecdotal reports of a person with a disability being unable to leave the provided transport at RHH and not being assisted to do so. If true this would be clearly of concern.
- A vulnerable prisoner showed us his duress alarm. He told us that it was regularly tested. We did not test it to gauge the adequacy of the response.
- One cell which was being used by a man with some disability issues was distressingly foul smelling, possibly arising from a lack of self-care. He had some prisoner personal carers who assisted him, but none the less it appeared to be difficult to maintain the basic levels of personal hygiene that are required.
- A number of cognitive assessments are undertaken as part of contributions towards NDIS evaluations. These are increasing in frequency.
- One prisoner had requested a mattress for his chronic back problem, and there appeared to be some difficulty in assessing his need for this, then providing it for him.
- One prisoner was told by his doctor that at night he should keep his legs elevated but was not able to do this as no pillow was provided.
- In the reception prisons many of the watch house cells only provided a mattress on the floor. LRP did not have a watch house cell with a platform provided despite this being necessary for those who were elderly or who have mobility or hip problems. Rather, prisoners are given two foam mattresses and a plastic chair if they have mobility issues.
- Access to health care for those who cannot fill out a request form is difficult. Currently they need to use a carer but this is not very confidential.

- A man with poor vision told us that his access to the canteen had been curtailed because he was unable to complete the requisite form.

Recommendation 71

Assistance to those with disabilities to complete the requisite forms for services should be provided.

Care for the terminally ill

The Inpatients Unit was providing palliative care to a man with a terminal diagnosis. It was notable that as part of this it was unable to provide him with palliative psychological care which is usually offered in such circumstances.

It was flagged that TPS and CPHS have not established a protocol or procedure in the event that a prisoner wished to access voluntary assisted dying. The Custodial Inspector's information request has prompted discussion between TPS and CPHS but it would be good practice to have the details settled about how access can be provided prior to a request one day being made.

Recommendation 72

Tasmania Prison Service and Correctional Primary Health Services establish protocols to ensure prisoners have appropriate access to voluntary assisted dying.

Hepatitis treatment

HCV treatment access is good but limited. After receiving treatment, some prisoners who use drugs are 'forced to use' dirty needles because of lack of access to a clean fix, for example through a needle exchange scheme (see harm reduction below). These prisoners are at risk of being re-infected with hepatic and other blood borne diseases. As HCV treatment is only available a few times, prisoners choose to be

treated only when coming up to release (as once released they are more able to access clean fixes).

Patient with special healthcare needs

The Inspection team met a prisoner with a range of very significant health problems. Some of his difficulties may have been caused by deficient care, and he was actively seeking legal redress, so it is inappropriate to comment on the standard of care that he received. His care needs are now being met through the allocation of a personal carer (another prisoner) and frequent medical and nursing care appointments. His room requires regular cleaning to a clinical standard to prevent possible contamination and infection. It is not clear whether this was provided.

Criminogenic interventions and programmes

In considering substance use management, criminogenic interventions and programmes offered by TPS were considered. There are no specific programs relating to AOD, but this work is incorporated into the other programs that are offered as required.

In order to attempt to reduce offending, the risk–need-responsivity model of programming is the leading model used in corrective services in Australia and throughout the world. It targets specific interventions for people assessed as being at the highest risk of reoffending in an attempt to reduce reoffending. The main offending related needs targeted by the interventions are:

- impulsivity;
- pro-criminal activity;
- associates;
- poor family relationships;
- lack of work;
- drug and alcohol misuse; and
- poor use of leisure time.

In TPS there are 17 FTE who deliver programmes relating to criminogenic risk: these are mostly social workers.

The programs are mostly delivered in groups, and broadly based on principles derived from cognitive behavioural or dialectical behaviour therapy. Programs are resource intensive, typically two staff run a program for nine months for ten people. Skills development such as emotional regulation, perspective taking and problem solving is offered through various psychological approaches within these programs.

The provision of programs did not appear to be linked with prisoner's requirement to undertake therapeutic work before being granted parole. It seems that surprisingly

few people do not get granted parole because they had not undertaken programs – it did not appear to be a condition very often. Of course, this should never happen as it would denote a serious failure of sentence planning.

There has been no research undertaken into the effectiveness of the programs, for example by examining the recidivism rates of people who have completed a program versus those that have not. There is no research officer position and I understand none of the existing staff have undertaken any reviews into this area.

Recommendation 73

Evaluation of the effectiveness of criminogenic programs, especially in relation to substance use management, should be undertaken.

It has been found elsewhere that many criminogenic programs are more effective if they are delivered in the community as opposed to in prison, or at least if they straddle the two during a person's transitional period into the community. This is because their effectiveness erodes if they remain in prison after the conclusion of the course because of the prevailing prison culture. In addition, the skills they develop include reactions to triggers that only occur in the community, and with long delays to exposure to these triggers, these skills wither.

The program staff are currently accommodated in a unit that was going to be converted into a prisoner unit, so the offices are essentially cells that have been converted. Whilst a novel office environment, it is not widely incorporated into office design for a very good reason – that is it is oppressive. It does not create a productive or creative work space, and does not send a good message to the professionals who are required to work there. They need to be found a more suitable long-term working environment. The Program team sees itself as marginalised, undervalued and deprofessionalised. It cannot seem to attract psychologists. Recent recruitment drives are ineffective. What professional wants to work from what is effectively a prison cell?

Recommendation 74

An alternative base for the Programs Team should be found so they are not accommodated in prison cells.

It seems that over the last two years or so very few programs have been running, if any. The COVID-19 pandemic and lockdowns had a profound impact on access to programs, which were significantly curtailed or stopped. In these circumstances it was impossible to provide consistent programs to the necessary standards (including regular groups). The program team outlined that during this period they offered individual programs into RBP instead.

Recommendation 75

Criminogenic programs, especially those containing information about substance use management, should be reinstated within the prison service. They should be closely linked to community services, and ideally straddle delivery of program services in the community after the participant's release.

Initially, a draft of this report specified that there was no information regarding programs being made available to women. The Department of Justice indicated, however, that a Dialectical Behaviour Therapy program was running inside MHWP, which has an AOD component. The recommendation below still stands given there is only this one program available to women.

Recommendation 76

Criminogenic programs, especially those containing information about substance use management, should be available to women when required.

Planning and integration back into the community

The area of sentence planning and integration into the community is a key function of corrections services. There is, however, little interaction between the TSU, Planning and Reintegration, and Program teams, each working in relative isolation from the other. The few brief interventions that are offered do not occur in a coordinated manner. There is little input to training or practice in case coordination, and little integration with community services. There is no dedicated case management team. Case management for prisoners is currently assigned to COs, however in practice this is being undertaken in a piecemeal and sporadic fashion.

There needs to be a more coordinated approach to case management, with consistent oversight.

Education programs and employment

Within TPS there appears to be limited education available, including basic numeracy and literacy. In addition, there are very limited training opportunities and next to no development of vocational skills. There is a TAS TAFE agreement to run meaningful courses, for example in scaffolding or working at heights, sufficient to gain a qualification.

There is almost no work available for remandees, and very limited access to education.

Where prison work is available for sentenced prisoners (such as cleaning or working in laundry or kitchen), it is often repetitive and is not meaningful or improving for the individual (other than to use up time).

Boredom is rife, and is soul destroying. Boredom can affect physical health, through lack of physical activity and lack of attention to eating habits. Chronic boredom is associated with impulsivity and risky behaviour, including drug and alcohol abuse. The lack of education and meaningful work needs to be addressed to make positive changes to prisoners' physical health and substance use while in prison.

The Department of Justice provided a formal response to this issue and it can be found at Appendix 5. It has not prompted me to change my opinion based on my observations during the inspection.

Patients with alcohol and other drug problems

Substances

The illicit drugs available in prisons probably resembles those seen in the local community. The drugs which appear to cause most difficulties in prison however cause a number of issues:

- mental state deterioration;
- intoxication;
- aggression and violence;
- withdrawal syndromes;
- detoxification;
- abstinence management; and
- rehabilitation.

Nicotine and tobacco

Since 2015 all Tasmanian prisons have been smoke free. This has a very positive effect on overall health and should be emulated in all Australian prisons. Many prisoners welcome it: few expressed resentment. In having to cease regular tobacco consumption, prisoners are no longer exposed to its negative effects, but can also allocate their earnings to more healthy choices. Staff and visitors are not exposed to the hazards of the passive effects of tobacco smoke, or secondary smoke exposure. There were no known negative sequelae from the gradual introduction of the ban of tobacco in the prisons, as initially feared: the transition was carefully and well managed.

Unfortunately, there is no support provided for people withdrawing from tobacco after reception into custody. There is no nicotine replacement for withdrawal. The level of agitation on reception can be significant. A doctor we saw scoffed, saying that craving never hurt anybody. That is to fundamentally misunderstand addiction. The reason given for this position is that nicotine patches, which had been originally prescribed, were abused and so were stopped. The patches were boiled and cut with vegetable matter and smoked. Sparks for lighting ‘home smokes’ were generated using microwaves and sockets. People were bullied (stood over) for their patches. In the last inspection there was concern about the adverse health consequences of the use of these homemade smokes.

Furthermore, there is no peer mentoring, education, relapse prevention, or quit programs, and no nicotine available to reduce craving. There is no help for prisoners to remain smoke free after release – little health education or classes about how to prevent relapse. Many smokers (about 40%) stated they wanted to cease after

discharge but many relapse.[51] This seems to be a waste of a public health opportunity.

Recommendation 77

Review the policy regarding supports provided for tobacco cessation to ensure the humane treatment of those dealing with nicotine addiction and withdrawal.

Opiates

Opiates, mainly in the form of suboxone, are used and are widely available in the prison. Suboxone is buprenorphine (a long-acting partial opioid agonist) mixed with naloxone (an opiate antagonist) and is often used in the community to treat opioid addiction. It appears to be the drug of choice in many prisons because it is readily obtainable in the community and is relatively easy to bring into the prison. Buprenorphine can reduce cravings and other opioid use. It suppresses opioid withdrawal in those who are opioid tolerant, and others can get a mild euphoric effect. It is usually taken sublingually, intranasally or intravenously. Whilst relatively cheap in the community it fetches very high prices in the prison setting.

Rates of people with substance misuse disorders in prison

Approximately two thirds of male prisoners and three quarters of female prisoners used illicit drugs in 2018.[52] This was predominantly methamphetamines, closely followed by cannabis. People entering prison are four times as likely to report using in the preceding 12 months (65%) as people in the general community (16%).[53]

Availability of drugs in prison

Smoking of tobacco is rarely detected in the prison. It appears that prisoners are not attempting to smuggle it in. Cigarettes are no longer used as a currency.

Drugs and particularly suboxone are prevalent and are readily available throughout the prison (according to multiple prisoners). They are easy to get in and to divert. The illicit supply causes many problems within the underworld of the prison, being

[51] Australian Institute of Health and Welfare (2019)
[52] Australian Institute of Health and Welfare (2019)
[53] Australian Institute of Health and Welfare (2019)

one of the most widely used currencies, with stand over tactics, bullying, intimidation, use of threats and violence being some of the consequences. The detection of contraband and its use is therefore the focus of much activity.

Contraband management

The stated purpose of the contraband management policy is to prevent drugs (and other contraband such as alcohol) from entering the prison. There are several ways in which drugs can get into the prison, each of which has its own management strategies:

- The first is on or within prisoners as they enter either from the community, court, hospital or another facility. The prisons are in the process of installing high quality body scanners to detect finds on or within a person. If detected, there are procedures whereby that prisoner can be held in a cell with an isolated plumbing system, a ‘dry cell’, allowing isolation from the mainstream prison community until any internal item has been expelled and can be recovered. The prisoners undergoing that process for a few days are not continually observed, with observations performed every two hours and there is no call button available. In the unlikely event that an internal package broke, there may be a potential for an overdose to be undetected.
- The second is on or within the body of visitors. This is the most likely source, evidenced as drug finds and positive drug tests within the prison fell significantly during the COVID-19 pandemic when visitors were temporarily banned from entering, and resumed after the prison opened up to them again. Enhanced capability body scanners again are deemed likely to help. Regular dog patrols through prisoner areas are also known to be effective.
- The third is on or within the body of staff. This is more controversial, but is undoubtedly a route, particularly if staff have been groomed or are being coerced in some way. Staff are already scanned upon entry to the higher secure areas. These scanners could easily be upgraded to detect drugs. Staff could be regularly tested for drugs and their property searched, or by using drug detector dog patrols. This occurred unexpectedly at LRP during the inspection and fortunately revealed no finds. All participating appeared to cooperate, there was minimal disruption, people appeared to understand the procedure and reasoning, and no problem was detected. This is very encouraging. Not searching staff regularly does not make sense. A zero-tolerance policy for staff regarding drugs and alcohol as found in many other industries (such as oil and gas and mining) should be adopted. However, those being coerced probably require significant assistance and support in a non-punitive manner (particularly at the earliest stages) and this should be available. Training in the awareness and avoidance of bullying, grooming and coercion should be a key part of training and refresher training.

- The fourth route is through postal packages and deliveries. Buprenorphine can be dissolved on paper strips and mailed in. Scanning does not appear thus far to have eliminated this route.
- The fifth way is over the wall, with a projectile containing drugs thrown or flown via a drone and dropped over the wall to be recovered by a prisoner. Regular patrols, dogs, enhanced CCTV, detectors, scanners can all be used to minimise entry.
- Alcohol seems to be the only substance which usually gets manufactured within prisons rather than being brought in. A simple combination of sugars and grains can result in fermentation yielding alcohol and carbon dioxide. Alcohol finds appear to be relatively infrequent as there have only been 15 items listed in the contraband register since May 2021. This data may not be overly accurate though as the process of data entry is reliant on correctional officers remembering to enter the data into this specific registrar, which is one of potentially a number of paperwork requirements that may need to be completed following an incident.

Overall, drug finds are infrequent and appear to be dependent on intelligence coming in. Drugs sometimes get in through lack of rigour in enforcing existing policy, or complacency or familiarity with personnel or visitors.

Recommendation 78

Improve conditions within the dry cell, which is used to house prisoners suspected of internally concealing contraband, including installation of a call button and increasing frequency of levels of observation.

Recommendation 79

Increase screening of staff, contractors and visitors on entry and at random (including drug testing).

Urine analysis

If drugs are used within the prisons there are ways of detecting this. There is a mandated and enforced program of both random and targeted urine tests in prisons. The targeted tests occur after particular intelligence has been received. Random tests occur through the random computer selection of 10% of the prisoner population per calendar month. This list is published on the first of the month and tests have to be conducted within the month. A compliance of 95% is required. At the current population of prisoners, 69 tests per month are undertaken. Tests are not undertaken within two weeks of reception to allow for the metabolism of any drugs taken in the community prior to incarceration. Officers collecting samples are trained to ensure the integrity of all collected samples is maintained. Each test is sent to an independent laboratory in Victoria. An initial test screens for all drugs and if negative, the sample is not tested further and treated as negative. If positive for any drug, further, more detailed analysis of the sample is undertaken, and results provided. Refusal to be tested is automatically recorded as a positive and the prisoner treated as such. Results usually take a few weeks to be produced. Immediate dipstick testing is not performed.

The program aims for results for random tests that are less than 7.5% positive, and those for targeted tests are greater than 30% (the right people are targeted). Actual results:

Year	Positive rate (%)[#]	
	Random tests	Targeted tests
2020-2021	6.87	29.46
2021-2022	8.13	23.75
2022-2023*	6.12	16.39

*data available to November 2022 only

[#]positive rate is calculated as the (number of positive tests + number of prisoners who refused or were unable to provide a urine sample) ÷ number of tests conducted × 100. The number of prisoners who refused or were unable to provide a urine sample is included in this calculation as refusal to provide a sample is treated as a positive sample as per DSO 1.22 - Substance Testing.

According to DSO 1.22 - Substance Testing, targeted urinalysis testing occurs when there is ‘reliable or confirmed intelligence’ that a prisoner has recently misused drugs. The results in the above table indicate that despite the efforts of TPS, they may not be choosing the right prisoners for targeted urinalysis tests causing them to fall short of their 30% benchmark.

Data obtained from TPS shows that buprenorphine is the drug most commonly detected in prisoner urine samples in both targeted and random tests.

The National Drug Strategy Household Survey 2019 found that 16.5% of Tasmanians had used an illicit drug in the last 12 months.[54] The rate of positive random urine tests in TPS varied from 6.12% to 8.13% over the last three years. TPS is a secure facility and if it were reaching the goal of being a drug-free prison, the rate of positive random urine tests would be 0%. Although the rate of positive urine tests does not seem particularly high it does indicate that illicit drugs entering the prison are a persistent problem for TPS.

There was evidence during the inspection to suggest that drugs were readily available inside the prisons. There is a need to accept that the current interventions to prevent drug trafficking have not been sufficient and the prisons continue to have a significant drug and alcohol use problem. This shows that contraband detection and reducing supply (which is a worthy endeavour) has thus largely failed in making the prisons drug free. Once that is accepted, TPS might turn its attention more to reducing demand through the delivery of treatment for addiction, which is woefully inadequate.

Access to alcohol and other drug (AOD) treatment

This is insufficient to meet demand. Culled waiting lists of 14 months or more attest to this. In general, treatment for AOD interventions should be based on clinical need and not legal circumstance (such as placement, imprisonment for six months or more, or remand status which seems an unacceptably punitive (and lazy) non needs based way of rationing scarce resources).

We were informed that numbers accessing treatment services were dependent on places and possible prescribers available in the community after release rather than treatment places available in the prison. With respect to service providers, this seems that the cart is very much being put before the horse and does not seem a rational reason for limiting treatment accessibility in prison settings. If necessary, places for rehabilitation in the community need to be expanded to accommodate them rather than ignoring the problem and denying treatment needs in prison.

Recommendation 80

Base Alcohol and Other Drug waiting lists on all those who require the service, not on legal status. Use this waiting list to assist making the case for development of Alcohol and Other Drug services.

[54] Australian Institute of Health and Welfare (2020)

Recommendation 81

Deliver Alcohol and Other Drug treatment to people who require it rather than limiting treatments to those for whom community services are being allocated.

Screening and management of AOD withdrawal

Screening on reception is required and undertaken to identify those in withdrawal after arrest who need detoxification treatment. Medical detoxification is the use of pharmacological treatments to minimise the symptoms of withdrawal immediately following a drugs cessation. It not always required as not all people using drugs are dependent, but its general aim is to achieve rapid, safe and humane withdrawal in cases of dependence. If withdrawal is detected, it appears that treatment for withdrawal is inconsistent, depending on the type of withdrawal, the site, the clinician and prevailing attitudes to addiction.

Alcohol

Alcohol withdrawal is unpleasant and can be complicated by a variety of symptoms including seizures, delirium tremens and other symptoms. There is much evidence available for the effective withdrawal from alcohol. A three or four day reducing dose of diazepam and thiamine is prescribed for alcohol withdrawal. Dosages and timescales can be adjusted for the amount of alcohol intake and intensity of withdrawal symptoms. There appeared to be no consistency in the provision of an alcohol withdrawal pack. The WHO recommends that all affected prisoners are treated for alcohol withdrawal, but detoxification is very inconsistent. Whilst the patient is withdrawing from alcohol, very often other psychiatric symptoms emerge, and mental health input is frequently required.

Benzodiazepines

In many cases withdrawal from long term benzodiazepines in particular is not appropriately managed. All medication in this class appears to be automatically just stopped on reception with no withdrawal treatment being offered as an alternative. This is a highly inappropriate practice. This was raised as an issue in the past report and persists. Those people who have developed addictions to benzodiazepines in the community which have been prescribed for chronic pain management have the dual problem of withdrawal as well as the pain for which it had prescribed returning.

It seems unnecessarily punitive. Withdrawal from benzodiazepines requires gradual tapering of the dose – long acting preparations are considered the most helpful.

Opiates

Opiate withdrawal is often an extremely unpleasant array of physical and psychological symptoms which can be both painful and debilitating. Withdrawal symptoms are sometimes objectively measured using the Clinical Opiate Withdrawal Scale (COWS) but its use is not consistent. The length of withdrawal is dependent on the severity of the preceding drug use. We were told that people received into prison found to be withdrawing from opiates are sometimes prescribed metoclopramide (for nausea) and hyoscine butylbromide (also known as Buscopan (for stomach cramping)) which can last seven days. It doesn't make much pharmacological sense to prescribe the two together as they interact and in effect cancel each other out.

The most effective treatment for withdrawal includes buprenorphine or methadone:[55] others that can be used include alpha 2-adrenergic receptor agonists such as clonidine or lofexidine. Using a short course of sublingual buprenorphine or Suboxone in the context may be problematic in some jurisdictions but a short tapering course is the most effective management of acute opiate withdrawal, so it should be explored. It is used in emergency departments and hospitals[56] according to a clear regime.

Opioids are legitimately used in medicine as a way of managing pain. If a prisoner comes in on legitimate script for pain management, and they may have developed an addiction, these drugs are denied and the emergent pain also inadequately managed. Opiate withdrawal is sometimes not taken sufficiently seriously in this group and may therefore be inadequately managed. There are treatment guidelines available,[57] but these are not used.

The consequences of inadequate availability of withdrawal treatment is the prisoner attempting to find relief in other ways, perhaps by feigning other symptoms to get treatment, intentional injury, or getting it from other prisoners, all of which cause many potential difficulties.

Methamphetamines

No specific withdrawal pack is given but staff ensure that prisoners withdrawing from methamphetamines are able to sleep and stay hydrated. Many sweat excessively during this period and if at HRP are kindly given fresh clothing and bedding every day: this could be easily extended to LRP. Consideration should also be given to

[55] Gowling (2009)
[56] SA Health (2020)
[57] SA Health (2020)

providing free deodorant in the first week in custody, as this is not included in the toiletries pack provided on entry.

Summary

Feedback received from CPHS and TPS staff, as well as prisoners and detainees was broadly consistent. Withdrawal packs appear to have been disbanded in favour of individualised prescribing. Whilst this has its advantages of prescribing undertaken to suit individual needs, it also runs the risk of idiosyncratic practices between clinicians and lack of consistency about prescribing regimens. In addition, a lack of a standard pack can create delay in administration. Several prisoners stated that treatment during this phase of acute opiate withdrawal was inadequate for them. It appears that assistance for people in withdrawal could be reviewed and improved.

Recommendation 82

Review policy and protocols regarding management of alcohol and drug withdrawal to ensure adequacy of care.

Opiate Replacement Therapy (ORT)

A well-established way of managing and controlling long term opiate addiction is to provide opiate replacement, whereby the opiate itself is replaced with an artificial less damaging substitute, which effectively tames the addiction whilst it is prescribed. The substitute used to be methadone, an oral preparation which used to be given out daily at different doses. This was problematic not just at the assessment and prescribing point but in administration, because methadone was easily subverted or distributed, and the security of the administration usually ensured the rest of the health centre had to shut down during this time, curtailing other activities. Even separate dosing areas did not solve the problem.

More recently an effective alternative injectable form has been produced at various doses, in the form of Buvidal. This is injected once per month and means that daily administration is no longer required. Buvidal is therefore preferred by both healthcare providers and, by and large, prisoners, if in sufficient dosage. It appears as if it is widely available for people assessed as suitable for opiate replacement. Only two prisoners in Tasmania currently remain treated with methadone: there are 70 who receive monthly injections of Buvidal.

It is recommended that people on Buvidal injection opiate replacement therapy receive the injection as part of a wider package of treatment, which includes therapy.[58] As with other types of therapy available for substance misuse in the prison, this part of the treatment program does not appear to have been sufficiently developed, and is not delivered. There is no rehabilitation offered as part of this program.

Recommendation 83

Include therapy as part of the opiate replacement program as per treatment guidelines.

The Schedule 8 programme (of which Buvidal is considered a part) did not have a good reputation amongst TPS staff because there was an erroneous belief that it was the source of most of the illicit drugs finding their way into the prison. When the supply of illicit drugs significantly reduced during the pandemic (when visitors could not enter and bring it in) it became apparent that visitors were the primary source and not the program.

The opiate replacement program is operated by CPHS. We were informed that the program was limited by the number of places available in the community to ensure continuity once prisoners are released. This limit does not appear to have been set clinically and the need for dosing is higher than this, thought to be about 20% of the prison population rather than 10%. If all those who required it received it, it may in fact reduce a significant number of other problems that the prison faces.

The clinical criteria for Buvidal is strictly set. Those entering the prison already receiving it in the community will generally have it continued, as they will already have been through an assessment process. Significant delays in continuing the community script (up to ten days) were reported. In contrast it appears to be very difficult, if not impossible, to get onto the program if not previously on it from community. Why this is the case is not clear. Many prisoners who need it cannot access the program. Those who need it should get it. The opportunity to address their drug and alcohol addiction issues appears to be being wasted.

Multiple prisoners believe that in order to get onto the program they are required to provide three positive drug urine tests (this is indeed one of the many clinical criteria), which they ensure they do. The stated reason for this is to ensure that anyone who is entered onto the program does in fact have an ongoing opiate use problem. This is all very well, but this policy has the effect in the prison of artificially

[58] Department of Health and Human Services (2012)

encouraging drug use just to get on the program. This policy needs serious reconsideration as it may do more harm than good.

Recommendation 84

Review criteria for placement on Opiate Replacement Therapy.

Therapy programs

There is currently only one specific alcohol and drug program available in Tasmanian Prisons. This is called Gottawanna, provided by Holyoake, an external NGO provider. This program is run only in RBP. It is provided however for up to only ten prisoners. There was little external NGO partnership in evidence.

In the past two alternatives were provided. Apsley was a residential program which stopped prior to the COVID-19 pandemic as it was seen as ineffective. Indeed, up to 90% of participants appeared to lapse back into drug use shortly after graduating from the program. This may have been partly because it was incorrectly aligned in the prisoner's trajectory, not coming close enough towards the end, but nearer the middle of a sentence. After completing the program, prisoners would have to return to the medium secure part of the prison which remained 'awash' with drugs, so they returned to using. Equip, another program, was also provided. Neither of these have been replaced.

We were informed however that several other criminogenic programs are provided, such as the Sex Offender Treatment Program (SOTP) or the Family Violence Treatment Program (FVTP), and these contain modules relating to substance misuse when these are relevant to individual offenders. However, some of these programs have not been delivered within the past year or two either (see below), due to staffing issues within the program team. Pathways, the specific drug and alcohol treatment program, has not been provided either.

There is a significant need to provide a residential therapeutic community therapy program to recovering sober prisoners, and the opportunity exists for programs to be developed which provide a transition out into the community and provide significant support during the high risk early stages of community living shortly after release. Many of these programs address not just substance misuse issues such as cravings and relapse prevention, but wider problems relating to the management of emotional arousal, anger, impulsivity and so on.

The establishment of a therapeutic community in RBP low security accommodation appears to be widely and strongly supported. We heard of plans underway to develop such a community in Ron Barwick Prison, to be provided in Division 8. This is a currently unused area which requires significant refurbishment (estimated to be at least $1m) before the project could proceed. We understand a case has been made for this refurbishment, but plans for the program are contingent on its success and are stalled at present, with no clarity over whether funding will be forthcoming.

Why this program could not proceed in another allocated area of RBP in the meantime was never fully explained. Two concerns were raised which could be easily overcome. Firstly, it was thought that separation from other prisoners who may be using drugs was needed because they somehow jeopardise a participant's sobriety and they may interfere with the running of the program. An agreed set of rules for participants should adequately manage this problem. Secondly it was explained that other potential difficulties providing such a program in RBP included not having enough prisoners to do the work in the prison that needed doing. For example, the kitchen and laundry (which are essential services) require a minimum certain number of prisoners per day to keep these functions running, and these prisoners come from RBP. If some prisoners were in a therapeutic program and were not available for work these essential services may be jeopardised. It seems that there are a number of fairly simple solutions to this problem. These include re-examining prisoners ratings and establishing whether any additional prisoners could be designated as low security and moved to RBP; or employing prisoners at higher levels of security, many of whom do not have enough to do (there are too few jobs available for these prisoners). The allocation of required jobs which can only be done by prisoners in low security to those prisoners seems fair enough, but those jobs which could be undertaken in higher security should be allocated to those prisoners. The possible withholding of necessary therapeutic programs to ensure day to day prison functions are carried out appears short sighted. In any event it should be possible for people in such a program to have part of their day working: this might also be usefully considered.

Recommendation 85

The leadership and structure of the delivery of Alcohol and Other Drug services is reviewed to ensure it is fit for purpose, contemporary and meets the needs of the prison population.

Recommendation 86

Parameters of eligibility for all Alcohol and Other Drug (AOD) treatments and programs need to be created which reflect patient need. Criteria based purely on legal parameters (e.g. remand status) should be abolished. Waiting lists should be then used where necessary to demonstrate service insufficiency. Adequate support and clinical supervision for AOD staff, including off site support where required, should be structured into the program and fully funded to enable all treating staff to have sufficient access as part of the role.

a. A space be identified for the delivery of a residential AOD therapeutic program pending the outcome of the business case for development of Division 8 in Ron Barwick Prison. Suitable prisoners should be identified for the program, moved to this area and the program initiated without delay. Whilst the program could be structured around the principles of Pathways, it needs multidisciplinary input and close integration with community AOD services, and with community services. Any carefully generated culture needs maintenance, or it can erode over time and this reduces program effectiveness.
b. Custodial and therapeutic staff for this unit should be carefully selected.
c. The effectiveness of the program should be evaluated.

Overall, the level of AOD therapeutic activity appeared to be distinctly lacklustre. There appeared to be little activity and little enthusiasm. Reasons given were a lack of staffing and a lack of space. There are plenty of prisoners who require significant work in this area. The amount of work provided was disappointing. The area needs a significant invigoration and sustained leadership to bring it back to the levels of input required.

The programs available for women were unclear. There seemed to be no plans for a similar AOD residential program for women.

Drug and alcohol counselling

There are lengthy waiting lists for drug and alcohol counselling but only two drug and alcohol counsellors are employed by TPS, for 690 prisoners. Community corrections have only one employed counsellor, a lonely position indeed. The waiting lists are artificially kept low because no one who is in custody on remand or sentenced to less than 12 months is considered: the waiting list is at least 14 months. This means

that many ‘revolving door’ people with recurrent short term sentences, but with nonetheless serious AOD problems, are neglected.

Counsellors do not cover for one another when they are on leave, nor are their positions backfilled. There is insufficient space for them in which to operate. Counselling is therefore very difficult to access. This is a long- standing problem that has not been addressed since previous reports.

We heard that further positions were promised by the Minister in Parliament,[59] but these were diverted to the planning team instead, much to the disappointment of the counselling team. There was agreement that at least six positions are required, but no immediate plans for expansion of the service were presented. We heard that other providers such as the NGO sector or the Tasmanian AOD Service could provide services at negligible cost within the prison if they were permitted to enter the prison. Space would be needed for these staff in which to see prisoners.

Recommendation 87

Develop a business case for the establishment of an adequate number of Alcohol and Other Drug counsellor positions.

The counsellors are located within the therapeutics department. There have been issues with lack of support and clinical supervision provided. One counsellor had to access such clinical supervision privately: it should be provided to ensure sustainability of the service and protect the counsellors. This has also led to the real risks of burnout and vicarious trauma in therapists not being addressed and these risks have been realised, with significant consequences for the team members and the service overall.

People self-refer to the service which tends to deliver individual counselling rather than counselling within groups, unlike many jurisdictions, and this takes the form of psycho-education, harm reduction, and relapse prevention.

Harm reduction

Within the substance use service arena, harm minimisation often includes demand reduction, supply reduction and harm reduction. Demand reduction requires linked treatment approaches in community and prison, including trauma informed

[59] Parliament of Tasmania (2021)a;b;c

approaches to care, good psychosocial management, accessible and adequate treatment for addiction and recovery from dependence. It includes ongoing robust mental health service input and ongoing care. Some of this is addressed in the paragraphs above, but it appears this overall needs reinvigoration. Supply reduction includes controlling the entry of drugs into the prison: this is addressed above, but does not seem very effective.

Harm reduction, the third arm to harm minimisation, is where techniques are used to reduce harm where drugs are used and other high risk behaviours occur, but without encouraging these. Current strategies include minimising the risks of use, including any adverse health and economic consequences of use. This includes blood borne virus management (Hepatitis B vaccination and screening, and treatment programs for HIV, HBV, HCV), methods to prevent transmission of blood borne viruses (which often originate from drug use via contamination with dirty needles), provision of naloxone (an opiate antagonist used to prevent opiate overdose), opiate replacement therapy, sexually transmitted infection screening and treatment and provision of condoms and dental dams.

Other programs which could be included involve the use of bleach sachets (as used in other jurisdictions) to clean needles, provision of clean needles and needle exchange systems (used in European jurisdictions which ensures that when needles are used at least they are clean), and use of supervised injecting rooms (used in Canadian prisons). There is no evidence that any of these interventions enhance use, although such concerns are often used to block such provision. These programs reduce needle-sharing and blood-borne virus transmissions and there is no evidence of negative consequences.[60] It is however known that after clearance of hepatitis infection, one third of cases become re-infected through sharing of needles. This can easily be prevented.

Recommendation 88

Introduce bleach needle-washing facilities and/or introduce needle exchange facilities.

Education of officers and health staff

During the inspection multiple custodial officers including some in very senior and influential positions, as well as some health staff, betrayed some misinformed old

[60] Lazarus (2018); Moazen (2018); Schwitters (2014)

fashioned, stigmatising and obstructive views relating to people with drug and alcohol problems and services required to treat them. An education program followed by a harm reduction conference might be of value to assist all staff in developing more helpful, informed and contemporary evidence based opinions about the arena.

Recommendation 89

Alcohol and Other Drug services deliver a range of education programs to Correctional Primary Health Services staff and Tasmania Prison Service staff regarding drug use in prison and treatment approaches.

Service links

The drug and alcohol service in the prison appears somewhat fragmented and operates without significant links to the community. It has not been strongly supported by or integrated with the community alcohol and drug service. As a consequence there appears to be little continuity of care of prisoners with addictions bouncing between the prison and the community. Community services are stretched and people going to or emerging from prisons may not be their top priority. Very few opiate users are not also poly-drug abusers and these are excluded from many community provided programmes. It is often not clear why. Links between prison drug and alcohol services and community mental health services are equally tenuous, despite significant co-morbidity and cross-over of people requiring input from other services.

Model of care

We understand that a Model of Care for AOD services is in the process of being established. It will require multiple stakeholder involvement, engagement and ownership, all being appropriately represented (including TPS, CPHS, DoH, the Alcohol and Drug Service (ADS), NGO sector). This is encouraged in the hope that the rather fragmented current service provision with lots of uncoordinated ineffective elements can be brought together into a unified whole.

The ethos of service provision (for example a consultation liaison model with trauma informed individual care rather than group-based care, along with close community service involvement) could be clarified. A model which is facility based to provide more integrated rehabilitation might work but will need detailed exploration. It would

be helpful for the model to again highlight the high rate of substance misuse within the prisons, and would assist to focus clinical resources on areas of most need, and highlighting to others where capacity does not exist to deliver necessary services. It would help to highlight the existing lack of linkages between the service within corrections and community AOD services, and the necessity for forming multiple partnerships with other community providers to assist in delivering care, for example from the NGO sector. A Memorandum of Understanding between CPHS, TPS and the Tasmanian Drug and Alcohol service would assist in clarifying roles and responsibilities and where work in partnership can be helpful.

The ADS, who are leading this Model of Care work, indicated to the inspection team that this will be an inclusive project. Stakeholders will include CPHS, TPS, NGOs and people with lived experience of alcohol and/or drug addiction.

Recommendation 90

Develop a multi-agency interdisciplinary model of care for Alcohol and Other Drug service provision which extends into the community and uses the services of community providers who have contracts or Service Level Agreements to deliver coordinated services.

AOD conclusion

The current drug policy in Tasmania (as in most jurisdictions) resulting in the locking up of increasing numbers of people with substance misuse problems, is expensive and largely ineffective in curbing drug use. There are very many prisoners with substance misuse problems, but throughout the prisons a slightly punitive attitude regarding substance users was detected, and this extends to users of prescribed medication such as diazepam, smokers and people with alcohol addiction, and this may work to their disadvantage. There are insufficient staff to manage the substantial problem of drug and alcohol use by prisoners, although many prisoners told us that drugs are rife within the prison, and readily available. There are no drug free areas within the prison for those with addictions. Many people are released from the prison without having had the drug and alcohol services they have requested and need. It appears the prison is not being as effective as it could be in relation to making a positive contribution to the drug and alcohol problem in Tasmania.

Health promotion and research

Health promotion activities being undertaken in TPS include:

- Persistent pain self-management programmes to manage expectations and psychological components of pain,
- Health and Wellbeing expos (RBP and RPC-Medium),
- Bras behind Bars program,
- support of Red Cross – volunteers for change programme particularly in MHWP
- Chopped Liver Ilbijeri Aboriginal Theatre Company
- E-Workshops
- Women's Health day (breast screen, continence, pelvic pain, endometriosis)
- Tai Chi
- Yoga (Women's health Tasmania)
- User voice (lived experience group UK)

CPHS participates in five major research programmes:

- Regular AIHW (Australian Institute of Health and Wellbeing) prison health census
- The National Prisons Entrants Bloodborne Virus risk behaviour survey report – Tasmania has participated every year it has occurred and has an increased understanding of associated risks. This resulted in the funding of hepatitis C medications by the Commonwealth
- The National Prisons Hepatitis Network – (Tasmania CPHS has membership of the executive – which developed national standards for prisons, is developing KPIs and recommendations, undertaking audits of screening procedures and vaccination programs, with ongoing monitoring of reinfection rates. The last report resulted in various recommendations, including to update policies, address prevention testing and treatment, opt out for testing at reception, rapid testing and treatment pathways, regular retesting, referrals when required, and vaccinations against hepatitis B
- The National Prisons Hepatitis Education Project 2023 – this is a program designed for the prison sector, to evaluate the health impact of an education programme
- The National strategy for hepatitis C is to eliminate it as a public health threat by 2030, and this cannot be achieved without prison participation as this is where drug users are congregated and where heightened risks for transmission are significant, particularly through needle and syringe sharing.

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Adult health care inspection 2023

Appendix 4

Inspection photos

Office of the Custodial Inspector Tasmania

Inspection photos

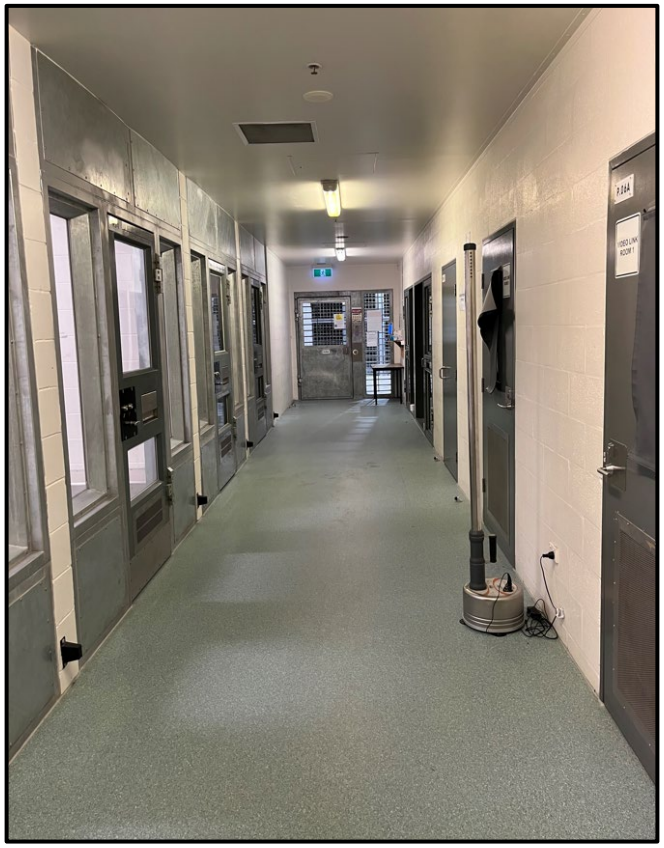
The photos below were taken for our mental health care and physical health care inspections. The photos relate to matters discussed in the Custodial Inspector's report and/or our consultants' reports or provide general context to health care in Tasmanian Prisons.

Risdon Prison Complex - Crisis Support Unit

1. Crisis Support Unit exercise area. Prisoners in this area can see, and be seen by, prisoners using the undercover walkways in Risdon Prison Complex medium security. Note the vine growing up over the exercise yard wire, this will provide more privacy once it grows.

2. Crisis Support Unit cell with a mattress and canvas blanket.

Risdon Prison Complex - Reception



3. Reception corridor containing dry cell, reception holding cells and video link rooms (photo taken at night).

4. Reception corridor with dry cell on the right. Note the prisoner's jumper being used to partially cover up the door's top window (photo taken at night).

Launceston Reception Prison - Observation cells

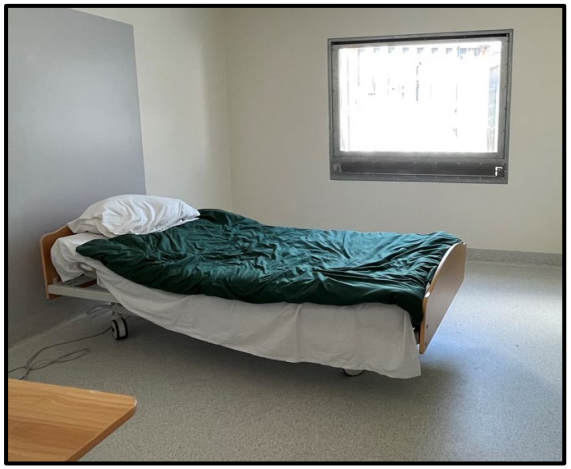
5. Corridor showing two empty observation cells (lilac doors) as well as some watch house cells. Photo was taken at night.

6. Observation cell with screened toilet and mattress (leaning up against the wall) and canvas blanket.

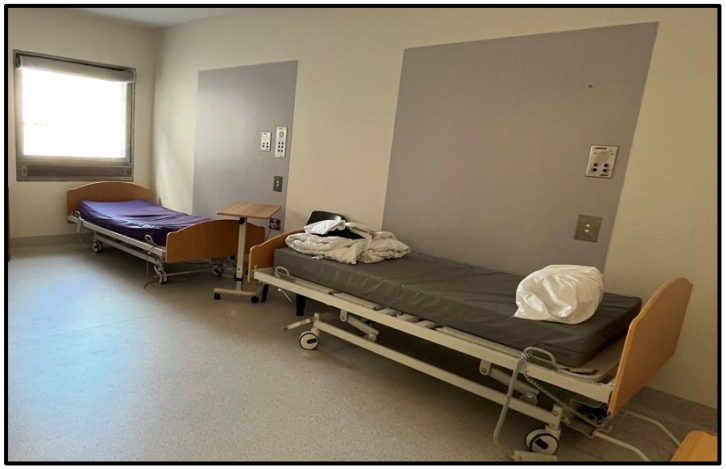
Risdon Prison Complex - Inpatients Unit

7. Inpatients room in older area of unit.

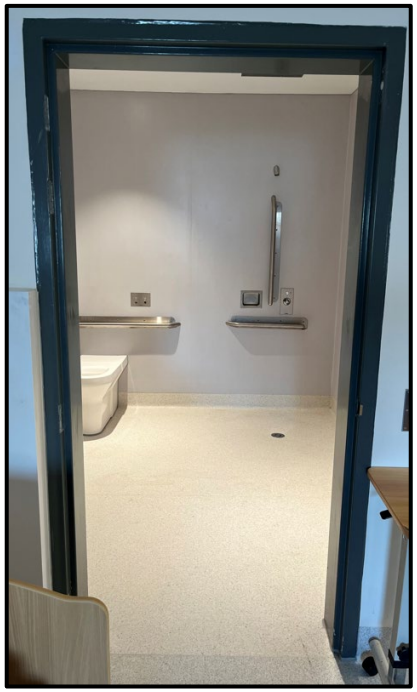
8. Inpatients room in older area of unit.



9. Inpatients single room in the newer area of the unit.



10. Inpatients double room in the newer area of the unit.



11. Inpatients bathroom (part of the double room in photo 9) with missing door.

12. Door (from bathroom in photo 10) that had been ripped off its hinges by a patient and was lying behind the staff desk of the new inpatients area (left).

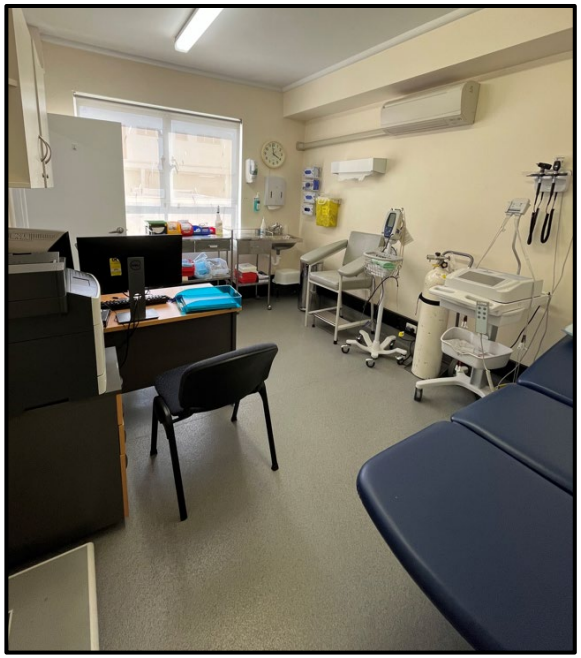
13. Inpatients outdoor space in older area of the unit. Tasmania Prison Service no longer allows prisoners to access this area.

14. Inpatients outdoor space in older area of the unit, showing sign on door stating that prisoners are not permitted to access the area (shown in photo 12).

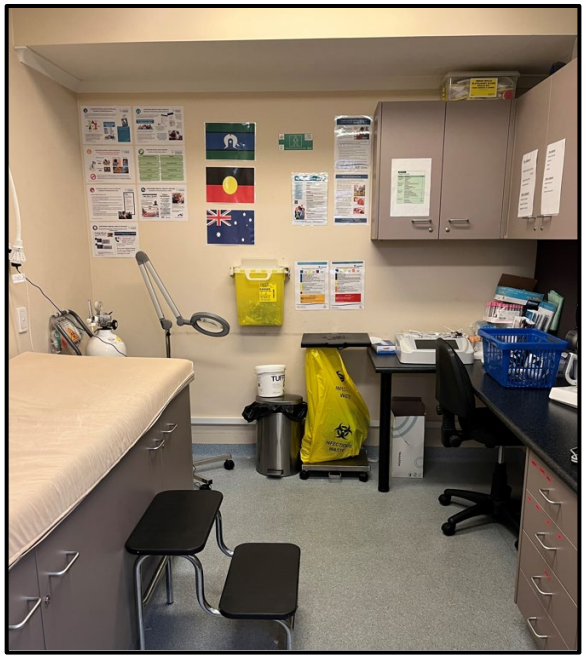
15. Inpatients outdoor space in newer area of the unit.

Clinical Spaces

16. Risdon Prison Complex physiotherapy space.

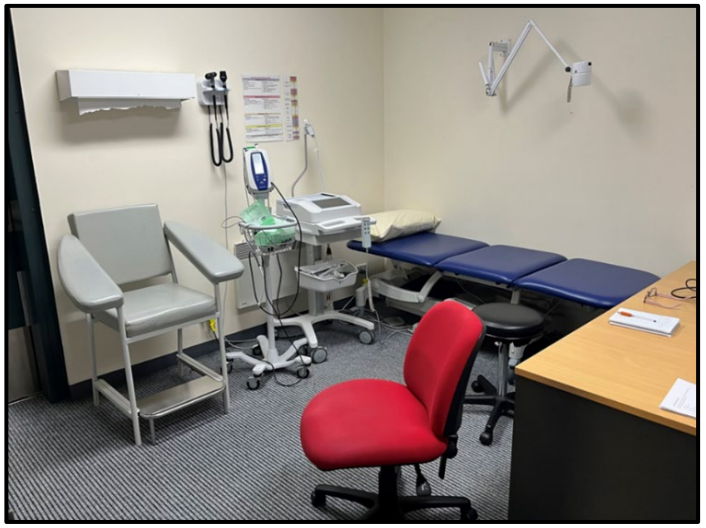


17. Ron Barwick Prison clinic space.

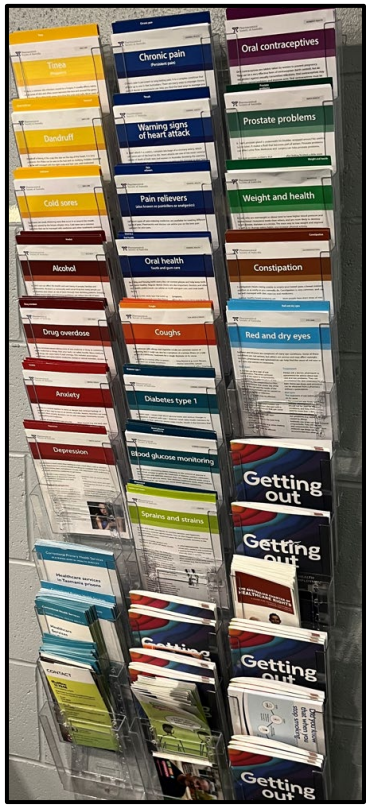


18. Launceston Reception Prison clinic space.

19. Ron Barwick Prison dental space.



20. Hobart Reception Prison clinic space.



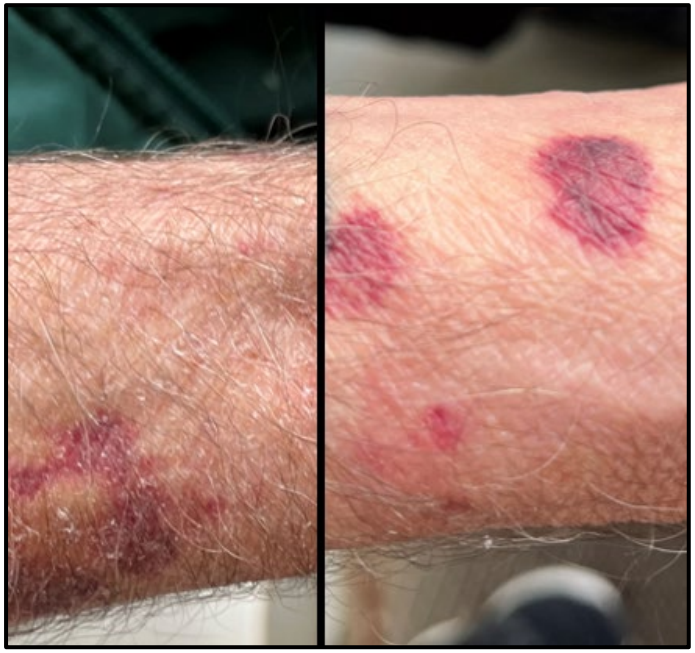
21. Hobart Reception Prison patient information.

Emergency Response

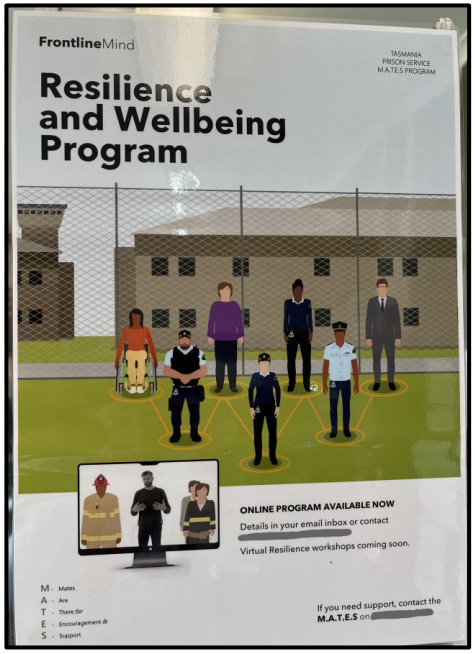
22. Emergency medical bag carried by nursing staff in response to ‘code blue’ (medical) incidents – opened to indicate types of equipment carried by staff.

23. Emergency medical bag carried by nursing staff in response to ‘code blue’ (medical) incidents – closed to indicate shape and bulk of bag.

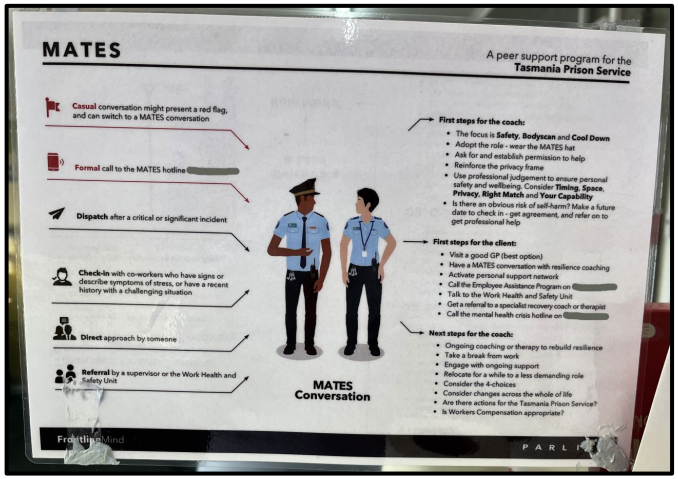
Other



24. Bruising on wrist of elderly male prisoner. The prisoner informed the inspection team that the bruising was caused by handcuffs used by custodial staff while transporting the prisoner to a medical appointment.



25. Poster advertising a resilience and wellbeing program available to correctional officers.



26. Poster advertising the Mates Are There for Encouragement and Support (M.A.T.E.S) peer support program available to correctional officers.

Please note: some photos have been edited to cover images, graffiti, or other information that contains personal information or may identify someone.

Adult health care inspection 2023

Appendix 5

Department of Justice response

Office of the Custodial Inspector
Tasmania

Department of Justice
OFFICE OF THE SECRETARY

Level 1, 85 Collins St, Hobart TAS 7000
GPO Box 825 Hobart TAS 7001
Phone 03 6165 4943
Email secretary@justice.tas.gov.au Web www.justice.tas.gov.au

Tasmanian Government

Mr Richard Connock
Custodial Inspector

Email: ci@custodialinspector.tas.gov.au

Dear Mr Connock

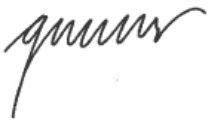
Departmental response to the Adult Health Care Inspection Report 2023

Thank you for the opportunity to provide a response to the Adult Health Care Inspection Report 2023.

The Department of Justice response is attached to this correspondence.

If you or your staff require any clarification or any further information, please don't hesitate to contact Tristan Bell, Assistant Director, Tasmania Prison Service at Tristan.Bell@justice.tas.gov.au or [redacted]

Yours sincerely



Ginna Webster
Secretary

7 June 2024

Department of Justice Comments

The Department of Justice (the Department) acknowledges the work undertaken by the Custodial Inspector, his staff and the contributions of Professor Kimberley Norris and Dr Edward Petch in relation to the Adult health care inspection report 2023. The Department also acknowledges and thanks its staff, TPS staff and staff from the Department of Health, including Correctional Primary Health Services (CPHS) for their cooperation with, and provision of information, advice and expertise to the Custodial Inspector.

The Department gratefully acknowledges the commendations of Professor Norris and the identification of areas of strength that the TPS can build upon.

The Department acknowledges that optimising the mental and physical wellbeing of prisoners is of critical importance and that people in custody generally have higher rates of mental health conditions, as well as chronic disease, and substance abuse. The Department and CPHS work in partnership to ensure continuous improvement in health outcomes for prisoners and to deliver health services to prisoners that are equivalent to the health care provided to the general Tasmanian community. This report provides a valuable opportunity for the Department to reflect on current practices as well as the broader prison environment, and make necessary changes to improve the mental and physical wellbeing of prisoners and staff, and the Department is committed to working with the Custodial Inspector to address the findings of the report.

The Department acknowledges that the Department of Health (though the CPHS) and the Department of Justice bear a shared responsibility for many of the recommendations throughout this report. The Department of Justice is supportive of assisting the CPHS to adopt recommendations which are predominantly the responsibility of the CPHS, noting resourcing and financial constraints, and look forward to working closely with the Department of Health to implement these recommendations.

The Department thanks the Custodial Inspector for the opportunity to provide comment on the draft report and responses to the recommendations, noting that there have already been a number of matters that have been reviewed since the inspections were undertaken in 2022 and early 2023. The Department has provided some additional comments about

specific matters below and also met with the Custodial Inspector to highlight some inaccuracies in parts of the report for his consideration, and trusts that where errors of fact were made they have been corrected.

The Department is of the view that some areas highlighted in the report require brief comment and this commentary follows.

Lockdowns

The Department remains committed to reducing lockdowns and ensuring that, as often as possible, prisons remain fully unlocked.

- As recognised by the Custodial Inspector in his 2021 Lockdown Review, lockdowns within a correctional environment are sometimes necessary and unavoidable. They are utilised to ensure a safe and secure correctional environment for prisoners, staff and visitors.

- It is important to note that when lockdowns do occur, essential services and prisoner supports are still maintained where it is safe to do so. On days where lockdowns are in place the TPS aims to continue to facilitate visits, both personal and professional, escorts and court appearances as normal and works to ensure that wherever possible all essential activities, including access to health care, occur as normal or with as little impact as possible.

- It should also be noted that when lockdowns occur, in many cases a prisoner may be confined to their unit and free to associate with others, and not confined to a cell.

- It is acknowledged that in the majority of instances the cause of the half-day or full-day lockdowns is staffing issues (shortages, absences and training requirements). However, it is important to note that there are an additional number of factors which cause lockdowns, and therefore impact on the time that prisoners receive out of cell. Many of these factors are outside the control of the TPS. These factors include the redeployment of staff for unforeseen medical escorts and hospital admissions, responses to critical incidents, faults in the Security Management System, and other operational requirements including the need to facilitate staff briefings and to undertake security searches. Areas may also be locked down following serious incidents or to manage heightened prisoner behaviour.

- The Department recognises that for the reporting period leading up to, and during, the Custodial Inspector's inspection, the use of full-day lockdowns was occurring in some accommodation units and areas. The Department does not use lockdowns other than when absolutely necessary and supports that full-day lockdowns should not be utilised, unless the use of such a lockdown would immediately address a safety or security concern.

- To address this issue, revised workforce planning strategies have been adopted by prison management, with the objective of ensuring daily time out of cell for all prisoners, and to achieve a more equitable balance of out of cell hours across the service. The success of this work to date can be evidenced through recent increased time out of cell averages in the mainstream accommodation units of the Risdon Prison Complex (see Figures 1 – 3 below). The Department continues to undertake additional work with relevant stakeholders to develop ongoing effective staffing strategies in the RPC which will have a positive impact on reducing the level of lockdowns that occur.

Figure 1. RPC Medium – Mainstream population

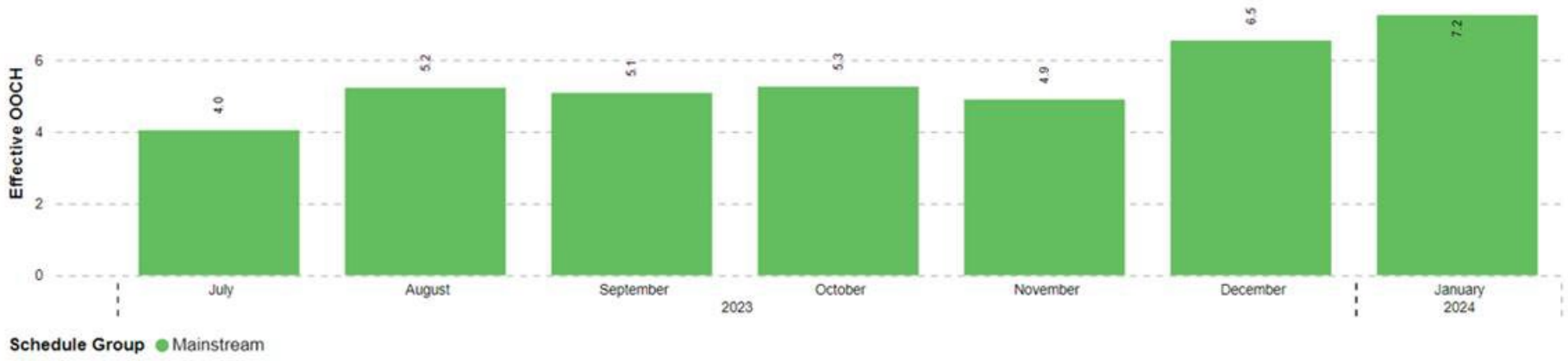


Figure 2. RPC Maximum – Mainstream accommodation Units

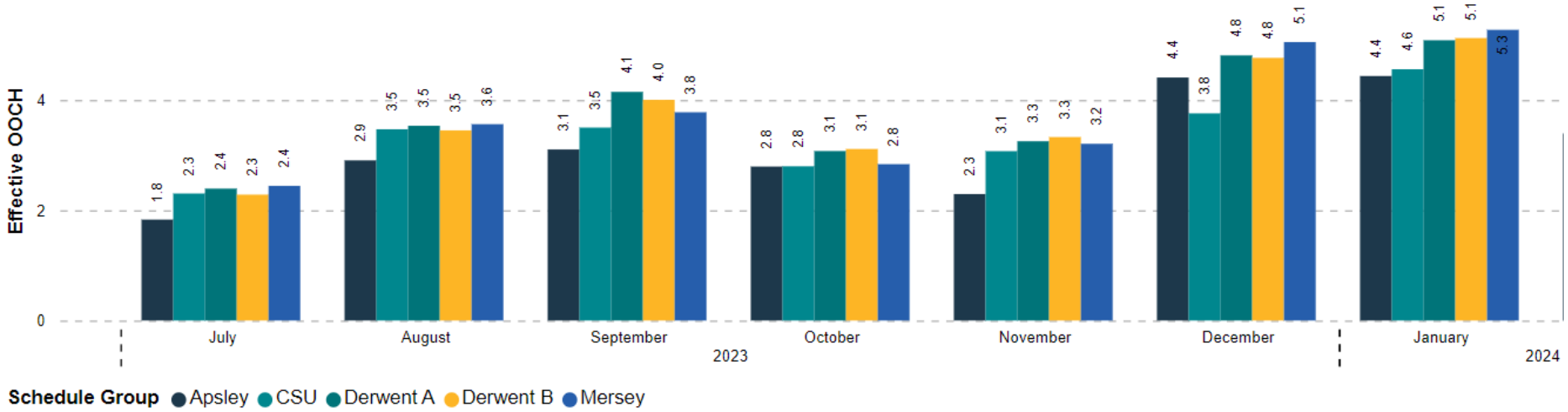
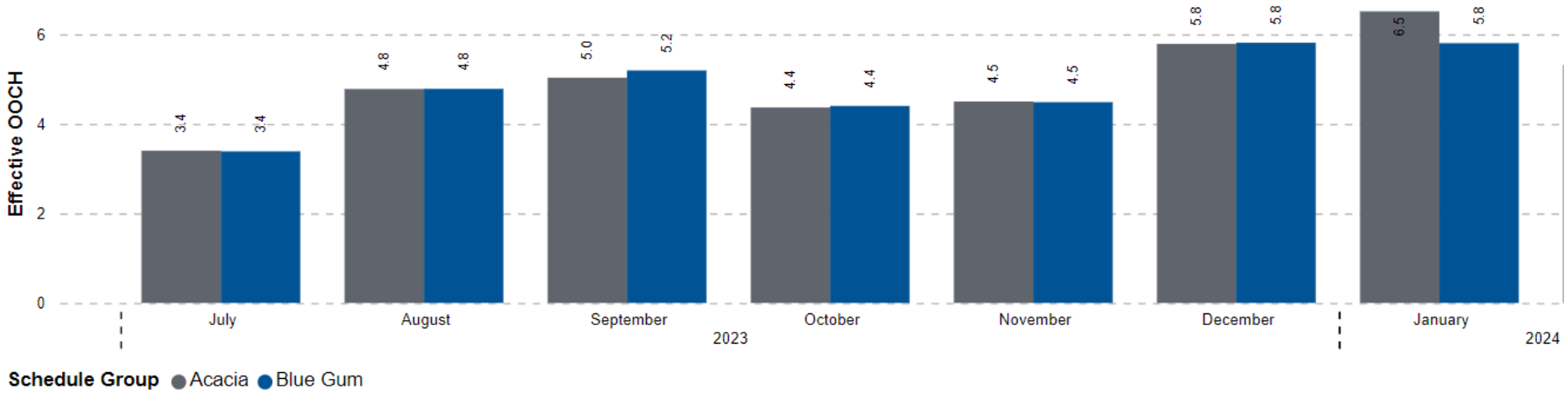


Figure 3. Southern Remand Centre



- While the Department does not endorse the characterisation of prisoners confined to their cell for a lockdown as segregation, it is acknowledged that confining prisoners to cells, particularly for a prolonged period, can have a negative impact on their wellbeing, similar to that of segregation. Despite the similarity in nature of a lockdown and segregation, there are also significant differences in impacts. For example, the level of privilege applied to a prisoner in segregation is vastly different to that of a prisoner confined to their cell for a lockdown, where they continue to have access to in cell entertainment, phones (where in-cell phones are available) and other privileges.

Incident relating to removal of medical officer's access to RPC

- The Department is strongly of the view that the commentary provided by Dr Petch in relation to the removal of access to the RPC of a medical officer is not a full or balanced representation of what occurred.

- The Department met with the Custodial Inspector and his staff and provided feedback about this section of the report and highlighted missing crucial information.

- It is noted that some of this information remains absent from the report.

- The Department endorses the findings of the Custodial Inspector that he has "not found any evidence that gender was a factor or had a role in the decision made by the Director of Prisons".

- It is disappointing that information provided by the Tasmania Prison Service to ensure the full facts and context surrounding this matter have not been included in the report, leaving the reader unable to draw factual conclusions based on the information that is provided.

- The Department supports the statement provided by Mr Ian Thomas, Director of Prisons in response to this section of the report.

The management approach of the TPS ('command and control')

- It is the Department's view that Dr Petch has significantly mischaracterised the TPS's position in relation to the 'command and control' style used within the TPS. The example provided in the formal briefing related specifically, and only, to control of incidents in relation to COVID-19 outbreaks and the successful way in which those outbreaks were managed.

- It was highlighted as an example of an effective way in which the TPS manage critical health incidents, rather than as a reflection on the broader management approach adopted by the TPS.

- The Department notes that the report acknowledged that the TPS response to the COVID-19 pandemic "appeared to be world class". The Department agrees with this observation and the TPS is to be commended for the exemplary response to the pandemic, through which prisoners and staff were kept safe and most normal operations of the prisons were able to be maintained.

- The TPS invested significant resources and time into ensuring that prisoners and staff remained safe throughout the pandemic and this caused significant disruption to the operations of the TPS and to TPS staff.

- Dr Petch appears to have taken a small targeted comment and drawn broad unsubstantiated conclusions based on that comment.

- The Department is of the view that when swift operational decisions are required to ensure safety and to control incidents, that a command and control style of management is appropriate.

- The Department acknowledges that a command and control approach has the capacity to be misused and the TPS is mindful of that and has numerous mechanisms in place to ensure that a collaborative and consultative approach is undertaken broadly across the TPS environment. Some of the current mechanisms include:

    - an expectation that managers consult with and work with their staff on matters;

- structured monthly meetings between TPS managers and union representatives;
- an active WHS Committee;
- numerous working groups to steer direction of projects, activities and policy;
- regular staff meetings held within facilities;
- broad consultation undertaken by the Policy Unit including recent educational workshops held within facilities and with non-uniformed teams to encourage feedback from staff, as well as an open invitation to provide feedback in relation to any policy at any time; and
- constantly examining issues pertaining to culture, and prison culture generally.

Infrastructure

- The TPS is continually improving the infrastructure of its facilities and has ongoing maintenance plans in place to ensure infrastructure remains in good condition and operational.

- The Department will continue to make the case for needed infrastructure additions and improvements.

- There remains a heavy active workload in new infrastructure development across the TPS with construction of a new kitchen soon to commence, plans well advanced for a new maximum security unit, and with the Northern Correctional Facility project progressing.

- In a fiscally tight environment, the TPS will always have more infrastructure enhancements that it would like to see progressed than can be achieved with the budget available. It is therefore a case that the TPS is constantly required to prioritise and rationalise the priority of infrastructure works.

Education programs and employment

- The Department strongly disagrees with the comments in the report in relation to the availability of education to prisoners. Whilst there is generally a reduction in education activity from mid-December to early February as a consequence of routine leave arrangements of teaching staff during this time (which would have been observed at the time of the inspection), significant education is consistently available throughout the year, and was still available during this time.

- Education offered includes a number of literacy based programs coordinated by Libraries Tasmania, tertiary preparation and tertiary courses with the University of Southern Queensland, Prisoner Education and Training (PEaT) digital literacy sessions in MHWP and RPC Medium, creative learning art classes in RBP, MWHP and RPC, and a number of TasTAFE courses. These TasTAFE courses include foundational numeracy and English, as well as more advanced vocational courses that provide employable qualifications.

- Additional vocational courses are available for minimum security rated prisoners eligible for section 33 and 42 leave.

- Whilst the Custodial Inspector comments that employment available to prisoners is often repetitive and ‘not meaningful or improving for the individual’, this statement overlooks many of the important factors related to the prisoner cohort. Many prisoners have little or no history of employment and a very limited educational background. For many of these prisoners, simply undertaking structured employment provides a skillset and habits which they have not developed in the community but which do assist them in future employment opportunities.

- There are also skilled positions that prisoners can work in, and skilled positions offsite where prisoners are supported to work. The TPS currently has a focus on increasing the level of employment available to prisoners, but is somewhat constrained by existing infrastructure.

- The TPS is also currently undertaking a systematic review of activities provided for prisoners with the intention of building upon current educational and vocational opportunities in a way that provides prisoners with further genuine pre-release and post-release pathways that reduces the likelihood of re-offending.

Department of Justice responses to adult health care recommendations

Recommendation		Acceptance level / Response
A	The Corrections Act 1997 be amended to ensure consultation at a senior level, appropriate to the circumstances, occurs prior to removing access to prison facilities for health staff and state servants. In the interim, the Director of Corrective Services, or their delegate, implement an internal process for consultation.	Not supported The TPS remains of the view that the Director of Prisons must retain the ability to refuse access to a prison to any person in the appropriate circumstances. Urgent matters may arise which risk safety, security and order within a prison which require an urgent response.
Mental health care		
It is noted 1, 3 and 7-15 relate specifically to the Ashley Youth Detention Centre, rather than the Tasmania Prison Service		
2	Employee Assistance Program (EAP) providers are specifically trained to understand and support staff working within custodial contexts	Not supported The TPS acknowledges that recommendations 2, 4 and 6 largely related to AYDC. The TPS already has a suite of resources available to staff as part of a holistic wellbeing program, which includes the Wellbeing Hub and the MATES Program, in addition to the EAP. This provides multiple support options for staff and a greater choice to find the support that suits their needs and preferences.

		The MATES Program provides particular context specific support for staff working in custodial contexts. Indeed, the MATES Program and the proactive mental health initiatives in place at the Department were subject to commendation 5 and 6 of Dr Norris' report (pages 55 and 56). **[now pages 110 and 111]**
4	As an interim measure, information be sought from other jurisdictions regarding their EAP providers and their organisational fit	Not supported The TPS's current mental health supports are fit-for-purpose (see response to recommendation 2).
6	Review the Award Wages to ensure that these are competitive to the external market	Not supported The Award Wages for correctional staff are determined in negotiations with workers and unions, and codified as part of the Correctional Officers Award. Other wages are covered by the State Service Award and Allied Health Professional Award.
16	Increased access to natural light and consideration of mental health needs in renovations and redevelopments of Reception Prison facilities	Supported in principle The TPS recognises that there are deficiencies in the design of the reception prisons, including with respect to natural light. Significant investment would be required to address this recommendation, noting that the existing infrastructure at the reception prisons does not easily lend itself to adaptation. Contemporary corrections design principles are being applied to all new infrastructure. The TPS's newest infrastructure maximises natural light and fosters a therapeutic prison environment with open spaces and freedom of movement, evidenced, for example, in the Southern Remand Centre. These principles will continue to be applied in the design of new infrastructure such as the new maximum security unit and the Northern Correctional Facility.

17	Mental Health training opportunities be provided to correctional staff in Reception Prisons	Supported Existing initiative. Mental Health First Aid Training forms part of recruit school training, including two full days dedicated to this component, as well as mandatory refresher training for all staff. As noted in Prof Norris's report, the Therapeutic Services Unit has designed, and is now delivering, a new training package for Correctional Supervisors in relation to neurodiverse prisoners. A new training package for correctional staff will be delivered following the finalisation of the review of DSO 2.02 Suicide and Self-Harm Prevention to support its implementation.
18	Appropriate resourcing and governance structures to support transfer of offenders with higher/more complex (mental health) needs	Supported Existing initiative. Noting that this recommendation was made in the context of the transfer of prisoners from the reception prisons, the TPS notes that these facilities are not generally used as long-term accommodation. Processes are already in place to ensure that prisoners received through the reception prisons are transferred to a longer term facility once their induction is complete. Processes also exist to ensure prisoners at risk of suicide or self-harm are appropriately assessed to identify the most appropriate facility for their placement. This includes consultation with the TPS Therapeutic Services Unit and CPHS, as well as correctional staff responsible for their management. Governance processes are also in place to manage the transfer of prisoners to the Wilfred Lopes Centre (WLC) in cases where higher and more complex needs are identified. This transfer is predicated on

		consultation between the Chief Forensic Psychiatrist and the Director of Prisons. The TPS also has governance structures to support the placement of prisoners in the Mersey Needs Assessment Unit within the Risdon Prison Complex which can provide a higher level of support and supervision than mainstream accommodation, and enables clinical staff at the TPS to undertake assessments of the prisoner's mental health needs with consultant advisory support from CPHS.
19	An MOU is entered into to facilitate assessments for treatment orders as required	Supported Existing initiative. Processes to facilitate assessments for treatment orders are already referenced in the existing letter of intent. The existing letter of intent between TPS and the Department of Health provides that the Department of Health are responsible for assessments of prisoners at initial reception including mental health, and the provision of statewide mental health services, including assessment for and provision of inpatient services at WLC.
20	Increased provision of mental health supports and services for prisoners in Reception Prisons	Supported in principle - Responsibility shared with another agency Existing initiative. The TPS is exploring resourcing options to provide increased supports in reception prisons. This may require further investment and is a shared responsibility with CPHS.
21	Increased health staffing/resourcing for adult prisoners	Responsibility of another agency Primary responsibility of the CPHS. The TPS is supportive of further resourcing.

22	Urgently increase TPS staffing resources to protect prisoners and staff	Not supported Noting the context of this recommendation related primarily to MHWP and the management of SASH risks, particularly in the Wellington Unit, the TPS notes that all correctional officers are trained in SASH risk identification and management. Further, two staff are rostered to the Wellington unit on a daily basis. These officers take a collaborative approach to the workload. Both officers are trained and understand the processes and protocols regarding HRAT management. The roster ensures that staff are not continuously rostered to Wellington. This enables all staff to have practical experience in that role and reduces any potential key person dependencies.
23	TPS and CPHS develop a designated inpatient unit for mental health presentations	Supported in principle - Responsibility shared with another agency Significant funding required to address this recommendation.
24	Develop and engage with, best practice models which cater to the needs of the Tasmanian adult prison population	Supported Existing initiative. TPS operating models and policies are based on current Australian Corrections guidelines, standards, and international law. The TPS has policies that specifically cater for gender diverse prisoners and prisoners with disability. Other processes make appropriate allowances for the diversity of the Tasmanian prison population. For example, disability is a mandatory consideration in the disciplinary process, and the lower risks generally posed by female offenders is recognised in the placement system in MHWP which is unique to that facility. All policy reviews as part of the TPS Policy Renewal Project include considerations of gender sensitivity, and neurodiversity.

25	TPS encourage and support peer mentoring and embed in formal workloads	Supported The TPS is exploring ways to formally embed peer mentoring for all staff; with a particular focus on new staff.
26	Staff mental health training be embedded into onboarding and ongoing professional development frameworks	Supported Existing initiative. The TSU provides training to all new recruits including: SASH, a brief mental health package, and a brief vicarious trauma, resilience and trauma informed practice workshop. The TPS is continuing to develop a Trauma Informed Framework. All staff are required to complete mandatory training every two years which includes a mental health module. Additional mental health training needs will be considered for inclusion by the training team.
27	Reflective practice and other forms of peer supervision be integrated into workload for all staff	Supported in principle There are well established peer supervision practices integrated into the workload for non-correctional staff. The TPS is exploring ways to integrate reflective practice and peer supervision into the workload for correctional staff, including options of piloting peer supervision and reflective practice in one facility. As noted in response to recommendation 25, peer supervision will form part of the introduction of a mentor program which the TPS is currently exploring.
28	Consider recruiting a staff member in Mary Hutchinson Women's Prison to the MATES framework	Supported in principle As noted by Professor Norris, this would be dependent on gaining the interest and consent of a staff member rostered to MHWP as this is a volunteer position.

		However, the TPS notes many MATES volunteers have lived experience as correctional officers and all volunteers receive specialised training to provide support regardless of the staff member's rostered facility. A facility-specific background is not critical to the provision of support.
29	Support TPS staff requests for training from mental health staff to increase mental health literacy, interdisciplinary learning and more coordinated mental health support for prisoners	Supported Noting that the TPS already incorporates extensive mental health training, the TPS is supportive of providing increased levels of training and supports to staff in this area.
30	A psychologist with specific knowledge and skills related to gang and terrorism behaviour continues to work with TPS in a consultant role to develop methods to manage prisoners posing a risk to others	Supported in principle - Responsibility shared with another agency The TPS intends to continue to engage with this psychologist.
31	Development of a structured, standardised and integrated system to assist in record management for offender mental health data	Responsibility of another agency
32	Existing policies are reviewed and updated to ensure that the mental health and wellbeing needs of staff working in a complex extreme and unusual environment typified by exposure to potentially traumatic events are appropriate to the context	Supported Existing initiative. The TPS is engaging in ongoing industrial discussions regarding a revised fatigue management and overtime policy which will include additional support following critical incidents.
33	Develop and review governance structures to better account for mental health and wellbeing needs of staff and prisoners as a matter of priority, ensuring these reviews are workloaded appropriately to ensure meaningful engagement	Supported A review of governance structures will be undertaken.

	and associated outcomes	
34	Implement a formal professional development framework in RPC to support implementation and consolidation of evidence-based, contemporary practices relating to therapeutic climate and therapeutic jurisprudence	Not supported However, the TPS is exploring the development of a professional development stream as part of TPS Training. Noting the context in relation to this recommendation primarily related to facilitating cultural change within the prison population, the TPS, in partnership with the Australian Red Cross, delivers the Volunteering for Change Program, based on the proven Community Based Health and First Aid in-prison program. The program trains prisoners to become Special Status Red Cross Volunteers within the prison and empower them to improve the health, wellbeing and safety of their prison community through identified initiatives. The program assists in providing prisoners with the skills to support a therapeutic prison environment and reduce stigma associated with mental health. This program is delivered in the MHWP and was expanded to the male prison estate in 2023. The introduction of facility-based teams will place therapeutic staff within facilities which will assist in normalising mental health outreach and provide a greater proliferation of staff to engage in prosocial modelling regarding mental health.
35	Health staff liaise with correctional staff to ensure that mental health screening and monitoring is considered as part of the dry cell management procedure	Supported As stated, *DSO 1.40 Managing Persons Suspected of Internally Concealing Items* is currently under review. This recommendation will be actioned as part of that ongoing review.
36	As a matter of priority, develop policy or documentation regarding the management of the mental health needs of older and very old prisoners	Supported - Responsibility shared with another agency TPS policy regarding the mental health needs of prisoners includes all ages, and includes individual assessments in conjunction with CPHS.

		The TPS supports a review of existing policies to ensure these policies sufficiently consider the unique needs of our older prison population. The TPS will need to engage and consult with CPHS and/or Statewide Mental Health Services in the review of the relevant DSOs.
37	Adopt early intervention models of mental health care	Supported - Responsibility shared with another agency The TPS will work with CPHS to implement an early intervention model.
38	Additional resourcing of existing research units/engaging with partners to undertake robust targeted mental health research focused on custodial contexts	Responsibility of another agency
39	Identify and implement evidence-based/evidence-informed targeted intervention programs of shorter duration for prisoners within the RPC serving sentences of shorter duration	Supported in principle Already an existing initiative with our facility based teams model and the planned work of the SRC team. The TPS and Safe at Home jointly won a funding bid from the Commonwealth Government (DSS) for Family Violence Interventions for People on Remand and Offenders on short sentences. The TPS will soon recruit two positions responsible for adapting the current TPS family violence intervention program to appropriately meet the needs of people on short sentence or remand. The funding for this project is four years. The TPS anticipates recruitment for the clinicians will be finalised by mid-2024.
Physical health care and substance use management		
1	TPS and Correctional Primary Health Services (CPHS) develop a set of principles for the delivery of healthcare services and monitor their services	Supported - Responsibility shared with another agency

	against these principles.	A review of the arrangements between TPS and CPHS is currently underway and this recommendation will be considered as part of that review.
2	If prison lockdowns are urgently required for regular training, they occur a maximum of one day per month.	Supported in principle This is not achievable with the current staffing model, but the TPS will continue to explore rostering options and continued recruitment to minimise lockdowns for this purpose.
3	During prison lockdowns, each prisoner who is confined to their cell is considered to be in a state of segregation.	Not supported The circumstances that exist when prisoners are locked down are significantly different than when they are in segregation. Principally, the conditions that relate when a prisoner is in segregation are significantly different. For example, prisoners in lockdown continue to have access to television and gaming consoles, receive canteen, engage in functional employment, may be taken to their usual appointments and visits and engage in programs and education, critical appointments still occur such as court attendances and critical medical appointments. Remandees in the SRC have unlimited access to telephone contact throughout any period of lockdown. This differs to prisoners on segregation who have limited access to some privileges or activities, and are subject to a higher level of operational security, but still receive essential services.
4	Prisoners in segregation have at least one hour out of their cell every day in line with the *Corrections Act 1997* and international humanitarian obligations.	Supported The TPS supports this principle.
5	People who are mentally ill are not subject to segregation unless it is by a specific order, such as disciplinary segregation or medical segregation.	Supported

		Segregation does not occur without a specific order being made. The mental health of prisoners and remandees is taken into account in relation to any order for segregation.
6	People in segregation should be medically reviewed according to international guidelines.	Supported The TPS supports this principle.
7	CPHS staff receive the appropriate training to be permitted to walk within the maximum and medium security parts of the prisons unaccompanied.	Supported - Responsibility shared with another agency Existing initiative. The TPS currently offers the appropriate training to CPHS to enable this occur. Not all CPHS staff choose to take up this currently non-mandatory option.
8	CPHS ensure appropriate standards relating to waiting times to see doctors are set and audited in a rolling cycle.	Responsibility of another agency
9	The business case for expansion of the available staff base with the opening of Southern Remand Centre (SRC) is reviewed and resubmitted.	Not supported The staffing model of the SRC is sufficient, effective and sustainable. Where lockdowns occur due to staffing issues in the SRC, this is related to individual staffing and/or standalone events, not the rostering of the SRC.
10	Staff on workers compensation considered to be permanently incapacitated should be removed from the TPS staffing establishment to enable recruitment into their vacant full time equivalents (FTEs).	Supported This recommendation is complete. This is an existing practice and is part of our ongoing work within the Injury Management Team. Section 143L of the *Workers Rehabilitation and Compensation Act 1988* requires an employer, for a period of 12 months commencing on the day the employee becomes totally or partially incapacitated by a workplace injury, make available the employment which the employee was engaged in immediately before becoming incapacitated, with some conditions.

		When an employee on workers compensation is incapacitated for a period of 12 months or more the employee is moved to a “holding line” where they still retain their permanent employee status, but may be transferred to a different facility or role upon their return to work, and the vacant role can be permanently filled.
11	TPS and the unions are both encouraged to reach agreement about staff numbers required to fully operate the prison and the threshold for when lockdowns are required on the basis of staff shortages.	Supported Existing initiative. Ongoing industrial discussions between the TPS and the unions are occurring.
12	TPS Senior Management Team (SMT) seeks external advice from a management consultant regarding the development of a change management process to replace the command and control culture into a more contemporary and effective management approach.	Not supported This recommendation would appear to stem from a misunderstanding of senior TPS staff’s position on command and control. The running a correctional facility occasionally necessitates swift operational decisions to respond and ensure safety and other matters. Outside of critical incident management, the TPS operates under a contemporary effective change management approach and undertakes extensive consultation and provides the ability for staff to co-create outcomes.
13	TPS SMT seek external advice from a strategic human resources management consultant regarding the development of an effective staff recruitment and retention strategy.	Supported in principle Existing initiative. The TPS has made use of recruitment consultants to support its ongoing recruitment campaign. In addition, the TPS has created a specific recruitment team to drive this work.
14	The Director of Corrective Services considers granting prisoners in segregation during lockdowns	Not supported

	special management days to the equivalent time they have been in lockdown and that this time is remitted from their sentence.	The TPS is focused on reducing lockdowns and increasing time out of cell. The TPS is of the view that the vast majority of lockdowns would not meet the criteria listed in the legislation for the granting of special management days and this would not be in line with the intention of the provision.
15	Training be provided for correctional staff about the role of health staff and vice versa.	Supported Training is currently provided on induction and through recruit training. Further refresher training will be considered.
16	Review the Letter of Intent between the Department of Health and the Department of Justice, and this to be shared with all staff from CPHS and TPS.	Supported A review of the arrangements between TPS and CPHS is currently underway and this recommendation will be considered as part of that review.
17	TPS to bring all standard operating procedures and Director's Standing Orders relating to healthcare services up to date and keep them under review.	Supported in principle - Responsibility shared with another agency The TPS has an established process in place for reviewing and updating DSOs. The TPS aims to review DSOs on a regular basis in a timely fashion.
18	CPHS Clinical Speciality group needs to meet at least six times per year.	Responsibility of another agency
19	CPHS acknowledge patients' medical requests and give a date by when they will be actioned or reasons why they will not.	Responsibility of another agency
20	Alert patients of their medical appointments without announcing it to the entire unit.	Supported The TPS is supportive of this principle.
21	CPHS acknowledge the receipt of complaints and	Responsibility of another agency

	provide a date by which they will be investigated and if appropriate, actioned.	
22	Feed findings from complaints into the Clinical Speciality Group for introduction into the clinical improvement process.	Responsibility of another agency
23	CPHS to establish a regular meeting with the Health Complaints Commissioner to discuss complaints, trends and outcomes.	Responsibility of another agency
24	All CPHS health staff need access to peer support and supervision, training, skills and career develop opportunities, cultural diversity training, and regular updates in clinical practice.	Responsibility of another agency
25	Provide more shaded areas to the yards in the SRC.	Not supported Remandees have uninhibited access to return inside from the yards in the SRC. Hats and sunscreen are also provided.
26	Review the terms of reference, including operation and membership, of the Use of Force Review Panel with the view to increase community input, including the Tasmanian Aboriginal community.	Supported in principle The current Terms of Reference for the Use of Force Review Panel allow participation from *ad hoc* members by invitation. The TPS considers that the addition of community members without relevant experience on the Use of Force Review Panel would provide little benefit to the process.
27	Provide, as a minimum, the Dedicated Response Team (DRT) and officers working with watch-house detainees with body cameras.	Supported

28	Obtain prisoner perspectives after every use of force so they can be fed back into the review of the incident.	Supported in principle The TPS supports obtaining prisoner perspectives where it is possible and appropriate to do so.
29	Review the violence reduction strategies that are in use to ensure they are contemporary.	Supported This will be considered in the broader context of a healthy prisons framework under development.
30	The State Government to consider how people on workers compensation can access the psychiatric care they require.	Supported Existing initiative. Through the workers compensation scheme all employees with accepted or pending workers compensation claims have access to various supports as directed by their treating team, including psychiatric services. The Department is aware there is a shortage of psychiatric services in Tasmania, and through the workers compensation system, employees are supported to travel interstate, where medically indicated, to receive in-patient psychiatric services.
31	Consider how best to support people on workers compensation or sick leave, especially in light of the Wellbeing Officer role no longer being funded.	Supported Existing initiative. The Department's Injury Management Team continually makes improvements to the work it does to ensure the best contemporary supports are being provided. Despite the cessation of funding for a correctional officer to be offline, the TPS MATES program is still active.

		Each employee with an accepted workers compensation claim has a dedicated Injury Management Coordinator and external Rehabilitation Provider. Once any notification of injury occurs, the injured employee is contacted by the Injury Management Team and provided support and referral to appropriate support services. The Wellbeing Support Unit has a Case Manager on site at the TPS each week, and employees can drop in, or make appointments to access this service. The Injury Management Unit has developed and implemented a range of supports, services and resources to support employees on workers compensation or with personal injuries including: • Injured Worker Kits • Refreshed and updated the Workers Compensation and Work Health and Safety intranet pages • Training for all new Correctional recruits. • WHS and Workers Compensation module delivered through the Ready to Lead program. • Supervisor Workers Compensation training package. The Department of Justice has engaged an external consultant to conduct a review of all the Department's wellbeing services to ensure they align with current best practice and that all services are evidence based. That review is expected to be completed by the end of April 2024.
32	Consider increasing nursing staff on duty in Hobart Reception Prison (HRP), as is done with correctional officers, during evenings and nights when there are public events likely to involve large crowds and substance use which may result in high	Responsibility of another agency

	numbers of arrests	
33	The medication management committee/ drugs and therapeutic committee should ensure all aspects of prescribing practice are in accordance with an established set of clinical guidelines for prescribing in correctional settings. Prescribing guidelines need to be developed where these differ from community treatment guidelines. A formulary needs to be agreed with clinicians.	Responsibility of another agency
34	All medication changes made at the point of admission (and thereafter) should be discussed with the patient before they are made. Until then drugs prescribed in the community should be continued unless contraindicated; wherever possible community health providers should be contacted for treatment information, and proposed changes discussed.	Responsibility of another agency The TPS notes that not all medications that are prescribed in the community are appropriate to be prescribed in a custodial facility due to the risk of misuse.
35	Electronic prescribing is established	Responsibility of another agency
36	Historical paper medication charts should be moved and stored off site in a central location.	Responsibility of another agency
37	The policy and practice regarding drug availability in imprests in various sites should be reviewed and standardised and brought into accordance with Tasmanian pharmaceutical regulations. If pharmacy input is required at Launceston	Responsibility of another agency

	Reception Prison (LRP) this should be organised.	
38	Commonly required medication should be available in imprests to avoid gaps in medication administration.	Responsibility of another agency
39	Evening medication rounds should be established particularly for sedating or psychotropic medication.	Supported in principle It is noted that this requires staffing input from CPHS, as well as TPS, and the operational impact of this will need to be considered.
40	A multi-agency review of medication security should be undertaken with a view to enhancing it where possible, so reducing the potential for trafficking of medication and therefore increasing the use of medication that is therapeutically useful but deemed trafficable.	Supported - Responsibility shared with another agency The TPS will support this review to occur.
41	The use of on-person medication be reviewed.	Supported in principle - Responsibility shared with another agency The TPS will support this review to occur.
42	Over the counter medication should be more readily available in the units. TPS and CPHS should work to establish an effective policy to implement this.	Supported in principle - Responsibility shared with another agency The TPS will work with CPHS to review options.
43	CPHS consider creating a list of medication that nurses across the prisons are permitted to dispense both with, and without, a prescription.	Responsibility of another agency
44	Medication be sent with prisoners to court with personal belongings as a matter of routine.	Supported in principle - Responsibility shared with another agency

		It is noted that daily medication already transfers with prisoners and remandees, and further work will be undertaken to consider the viability of extending this practice.
45	The post release medication practices should be reviewed and at least one week's medication should be sent with prisoners who are attending court or who are being released.	Responsibility of another agency
46	The criteria for access to dental care should be reviewed to include all patients, both sentenced and remandees, who meet the clinical criteria for care and they should be screened against these criteria by staff trained in dental triage.	Responsibility of another agency
47	CPHS should work with Oral Health Services to review and amalgamate the correctional and community waiting list to ensure people are not disadvantaged regarding their waiting times for dental treatment by virtue of changes to their custodial or legal status.	Responsibility of another agency
48	Dentistry services at the prison need to be doubled without delay.	Responsibility of another agency
49	CPHS to review input provided by allied health professionals and business cases prepared to increase input to meet demand where necessary.	Responsibility of another agency
50	Upgrade and mend the broken fittings in the Inpatients Unit.	Supported

		Complete. The broken fittings identified in the report have been repaired and future maintenance will be completed as necessary.
51	Refurbish the areas of the old Inpatients Unit.	Supported in principle The TPS has undertaken refurbishment of parts of the Inpatients Unit and further works are subject to funding.
52	Review TPS and CPHS staffing of the Inpatients Unit, particularly the reallocation of TPS staff to other areas during lockdowns.	Supported in part The TPS does not support the need for a review of staffing of the Inpatients Unit. The TPS is working to ensure that lockdowns do not have as significant an impact on the Inpatients Unit as currently occurs.
53	Review the use of the Inpatients Unit, the medical procedures that could and should be undertaken there, and deliver appropriate training to staff as soon as practicable to reduce the number of escorts to hospital.	Supported in principle - Responsibility shared with another agency CPHS to lead this review due to the clinical expertise required.
54	Review the security needs of the Inpatients Unit to allow immediate medical access to all rooms.	Supported - Responsibility shared with another agency Will be considered as part of the review of the Inpatients Unit.
55	Review the use, function and infrastructure of the Crisis Support Unit (CSU) to ensure it is a therapeutic space.	Supported The TPS is exploring solutions to improve the therapeutic nature of the environment. Extensive development would require significant investment.
56	Increase number of medical escorts to hospital back to eight per day without delay. This will take some work regarding resourcing, but it should be a priority.	Supported in principle The TPS acknowledges that resourcing will be required to enable this to occur and it is limited by that. Concurrently, the TPS is exploring with the CPHS/RHH alternative options to increase access to health care.

57	CPHS and TPS work with Royal Hobart Hospital (RHH) to plan the implementation of secure areas in the refurbished Emergency Department so they can be used by prisoners and escorting staff.	Supported in principle - Responsibility shared with another agency This has been a long-held view of the TPS. Significant infrastructure and funding will be required.
58	Develop a Memorandum of Understanding (MOU) with RHH and Launceston General Hospital (LGH) regarding mutual expectations and ways of working with prisoners to ensure their safety and welfare as well as that of the public. The MOU with RHH and LGH should also consider introducing regular visits of specialists to the prisons.	Supported in principle - Responsibility shared with another agency Existing initiative. Initial discussions with the RHH to develop a new MOU have commenced.
59	Review arrangements regarding escorts. Consider outsourcing of the transport function to an external provider while TPS is unable to staff the function to sufficient levels.	Supported in principle As above see response to recommendation 56. Consideration of this recommendation will occur.
60	CPHS to liaise with TPS staff in good time regarding escorts required.	Responsibility of another agency The TPS looks forward to working with CPHS in relation to this recommendation.
61	Increase use of video-conferencing and telehealth for healthcare, wherever possible, with outpatient clinics to minimise escorts required.	Supported - Responsibility shared with another agency Significant upgrades have occurred to the video conferring capacity of the TPS. The feasibility of undertaking telehealth and health care appointments by video-link will need to be explored with the CPHS, including with specialists and allied health professionals.
62	Review the level of information and support required regarding the management of menopause and related symptoms.	Responsibility of another agency

63	Incorporate the Volunteers for Change program into the male estate and into the CPHS clinical governance program.	Supported in principle - Responsibility shared with another agency Existing initiative. The Volunteers for Change Program was rolled out to the RPC medium security precinct during 2023, and will continue to be provided in MHWP and RPC Medium or Ron Barwick Prison in 2024. It is noted that the funding arrangement for this program is due to come to an end and ongoing funding will be required for the program to continue, and to expand the program into other areas of the prison.
64	TPS reintroduce the peer support service into Mary Hutchinson Women's Prison (MHWP).	Supported TPS is currently exploring options to engage an external support provider to deliver a peer support program in MHWP. The Volunteering for Change Program has a peer support component.
65	Develop Alcohol and Other Drug (AOD) rehabilitation services for women to reflect their level of need.	Supported Existing initiative. This is being delivered as part of the move to facility based teams. Since the inspection the TPS has recruited two additional Alcohol and Drug Counsellors and part of their role is to provide counselling specifically to female prisoners on request. In addition, the Dialectical Behaviour Therapy Program is delivered on a rolling basis in MHWP and provides significant levels of AOD support to women prisoners.
66	Mental health input to the MHWP may require review. An audit of need should be conducted and the input provided should reflect the level of assessed need.	Responsibility of another agency
68	TPS and CPHS should conduct a recruitment drive targeted towards Aboriginal and Torres Strait	Supported in principle

	Islander people.	The provision of health services to Aboriginal and Torres Strait Islander prisoners is currently being examined by the *Nous Group* through a National Review of First Nations Health Care in Prisons. In the Tasmanian context this is more complex than is perhaps anticipated given the span of the State's principal ACCHO does not extend to all people who identify as Aboriginal.
69	CPHS should ensure that culturally appropriate care is provided to people from Aboriginal and Torres Strait Islander communities.	Responsibility of another agency
70	The need for transitional case management needs to be reviewed given the impact it can have on recidivism. Transitional case manager positions should be created and a manager appointed.	Responsibility of another agency The Department notes that the context of this recommendation relates to the case management of mental health supports.
71	Assistance to those with disabilities to complete the requisite forms for services should be provided.	Supported Prisoners are not required to use a carer to fill out forms. They are able to request assistance from correctional officers and non-uniformed staff when required. The TPS will ensure these other support options are known to prisoners.
72	TPS and CPHS establish protocols to ensure prisoners have appropriate access to voluntary assisted dying.	Supported - Responsibility shared with another agency The TPS will work with relevant parties to review and update relevant policy to ensure prisoners have appropriate access. This will be undertaken as part of a review of DSO 4.15 End of Life Care which is scheduled for review during 2024.
73	Evaluation of the effectiveness of criminogenic programmes, especially in relation to substance use management, should be undertaken.	Supported in principle

		The TPS undertakes individual assessments pre and post program participation using peer reviewed tools to evaluate program effectiveness for the individual. TPS programs are evidence-based and the TPS is supportive in principle of undertaking broader evaluations of criminogenic programs subject to resourcing being available.
74	An alternative base for the Programs Team should be found so they are not accommodated in prison cells.	Supported Existing initiative. Programs Team members have moved into selected facilities as part of the facility-based teams model.
75	Criminogenic programs, especially those containing information about substance use management, should be reinstated within the prison service. They should be closely linked to community services, and ideally straddle delivery of program services in the community after the participant's release.	Not supported The TPS has consistently maintained the delivery of criminogenic programs addressing substance use management. It is acknowledged that residential substance use management programs that have previously been delivered were ceased due to priorities and staffing during response to the COVID-19 pandemic and the TPS continues to consider further options for a residential program to recommence within the prison.
76	Criminogenic programs, especially those containing information about substance use management, should be available to women when required.	Supported in principle The TPS offers programs and cessation of substance use supports to women. The Dialectical Behaviour Therapy Program is offered to women at MHWP on a rolling basis as the primary criminogenic program. The recent change to facility based teams will support the further delivery of interventions to women.
77	Review the policy regarding supports provided for tobacco cessation to ensure the humane treatment of those dealing with nicotine addiction and	Supported in principle - Responsibility shared with another agency The TPS provides support through access to AOD counselling, and the Quit Line. The TPS acknowledges the difficulty in providing nicotine

	withdrawal.	patches in custodial settings, and will continue to provide alternative supports.
78	Improve conditions within the dry cell, which is used to house prisoners suspected of internally concealing contraband, including installation of a call button and increasing frequency of levels of observation.	Supported The TPS is obtaining a quotation for the installation of an intercom in the RPC Reception dry cell and other improvements will be undertaken.
79	Increase screening of staff, contractors and visitors on entry and at random (including drug testing).	Supported in principle Broader legislative and policy amendments would be required for drug testing staff. Staff and their property are routinely searched on arrival to all higher security prisons, including random searches by drug detector dogs. Consideration will be given to increasing screening of staff, contractors and visitors.
80	Base AOD waiting lists on all those who require the service, not on legal status. Use this waiting list to assist making the case for development of AOD services.	Supported in principle The TPS is supportive of expanding the services provided, however funding is required.
81	Deliver AOD treatment to people who require it rather than limiting treatments to those for whom community services are being allocated.	Supported in principle - Responsibility shared with another agency The TPS has little control over the availability of community delivered services. However, the TPS is supportive of expanding the services provided but funding is required.
82	Review policy and protocols regarding management of alcohol and drug withdrawal to ensure adequacy of care.	Supported in principle - Responsibility shared with another agency The TPS will work with CPHS to review policy and protocols.

83	Include therapy as part of the opiate replacement program as per treatment guidelines.	Responsibility of another agency
84	Review criteria for placement on Opioid Replacement Therapy (ORT).	Responsibility of another agency
85	The leadership and structure of the delivery of AOD services is reviewed to ensure it is fit for purpose, contemporary and meets the needs of the prison population.	Supported The TPS will undertake a review.
86	Parameters of eligibility for all AOD treatments and programs need to be created which reflect patient need. Criteria based purely on legal parameters (e.g. remand status) should be abolished. Waiting lists should be then used where necessary to demonstrate service insufficiency. Adequate support and clinical supervision for AOD staff, including off site support where required, should be structured into the program and fully funded to enable all treating staff to have sufficient access as part of the role a) A space be identified for the delivery of a residential AOD therapeutic program pending the outcome of the business case for development of Division 8 in Ron Barwick Prison (RBP). Suitable prisoners should be identified for the program, moved to this area and the program initiated without delay. Whilst the program could be	Supported in principle The TPS will undertake a review to consider each of these factors.

	structured around the principles of Pathways, it needs multidisciplinary input and close integration with community AOD services, and with community services. Any carefully generated culture needs maintenance, or it can erode over time and this reduces program effectiveness. b) Custodial and therapeutic staff for this unit should be carefully selected. c) The effectiveness of the program should be evaluated.	
87	Develop a business case for the establishment of an adequate number of AOD counsellor positions.	Supported in principle The TPS supports adequate resourcing being available to deliver AOD services. In the 2023-24 Budget, funding of $375k p.a. was provided to facilitate increased drug and alcohol interventions to prisoners. Any business cases for funding need to be considered in the broader context of funding requests.
88	Introduce bleach needle-washing facilities and/or introduce needle exchange facilities.	Supported - Responsibility shared with another agency CPHS is currently reviewing options for re-introducing bleach needle washing facilities with the in principle support of TPS.
89	AOD services deliver a range of education programs to CPHS staff and TPS staff regarding drug use in prison and treatment approaches	Supported in principle - Responsibility shared with another agency The TPS will work with CPHS to explore options to deliver education and training to all staff.
90	Develop a multi-agency interdisciplinary model of care for AOD service provision which extends into the community and uses the services of community	Supported - Responsibility shared with another agency Existing Initiative.

	providers who have contracts or Service Level Agreements (SLAs) to deliver coordinated services.	In 2022, Statewide Mental Health Services commenced a multi-agency project titled 'Review of Alcohol and Drug Treatment for Tasmanian Prisoners'. This comprehensive review has enabled the development of a related Action Plan and the establishment of the Continuing Care: Alcohol, Tobacco, and Other Drug (ATOD) Treatment for People In, Entering and Exiting Secure Facilities in Tasmania Project (Continuing Care Project) Steering Committee. The Continuing Care Project Steering Committee consists of representatives from multiple government agencies, non-government organisations, people with a lived or living experience of ATOD use, and people with a lived or living experience as a family member, friend, or support person of a person who uses ATOD. The Action Plan was developed collaboratively with key stakeholders from relevant government departments (Department of Justice, Department for Children, Education and Young People), non-government organisations, and people with lived experience. Relevant SLAs will be put in place to support the work arising from the Action Plan.

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Adult health care inspection 2023

Appendix 6

Department of Health response

Office of the Custodial Inspector
Tasmania

Department of Health

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Tasmanian Government

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Dear Richard

Subject: Draft Adult Health Care Inspection Report

Thank you for the opportunity to make representations in response to the Draft Adult Health Care Inspection Report and its recommendations.

Our Forensic Mental Health Service, including Correctional Primary Health has reviewed the draft report and has identified where the Department supports them as well as comments and individual responses to each recommendation.

In some cases, the recommendations have been supported in principle, with the proviso that additional funding would be required to implement.

We have also identified recommendations that are already being implemented or are planned to be implemented in the near future.

If you require further follow-up on any of the recommendations, please contact Forensic Mental Health Services on 6166 0824 or email fhs.eso@ths.tas.gov.au.

I look forward to seeing the final report.

Yours sincerely

Shane Gregory
Associate

8 February 2024

Enc: DOH Response to Recommendations

Department of Health responses to adult health care recommendations

Recommendation		Acceptance level / Response
A	The Corrections Act 1997 be amended to ensure consultation at a senior level, appropriate to the circumstances, occurs prior to removing access to prison facilities for health staff and state servants. In the interim, the Director of Corrective Services, or their delegate, implement an internal process for consultation.	**Supported - Responsibility shared with another agency** TPS and CPHS have a dispute escalation process in place which provides for appropriate consultation should a dispute occur which could result in CPHS staff losing access to prison facilities.
Mental health care		
2	Employee Assistance Program (EAP) providers are specifically trained to understand and support staff working within custodial contexts	**Supported - Responsibility shared with another agency** EAP providers for CPHS staff are those contracted by the Department of Health and therefore do not have expertise in custodial settings. Should the TPS contract EAP services with expertise in custodial settings, CPHS would seek access to these EAP settings for CPHS staff where appropriate.
4	As an interim measure, information be sought from other jurisdictions regarding their EAP providers and their organisational fit	**Supported - Responsibility shared with another agency** CPHS welcomes the opportunity to work with TPS to explore the EAP providers in other jurisdictions.

6	Review the Award Wages to ensure that these are competitive to the external market	**Supported** CPHS staff wages fall under the Tasmanian Health and Human Services State Service Award. These wages are reviewed as part of Enterprise Bargaining Agreement negotiations to ensure they are competitive to the external health labour market.
16	Increased access to natural light and consideration of mental health needs in renovations and redevelopments of Reception Prison facilities	**Responsibility of another agency** The physical facilities of the prison are managed by the TPS. The Forensic Mental Health Service can provide advice on mental health considerations in any renovations or redevelopments of TPS facilities.
17	Mental Health training opportunities be provided to correctional staff in Reception Prisons	**Responsibility of another agency**
18	Appropriate resourcing and governance structures to support transfer of offenders with higher/more complex (mental health) needs	**Supported in principle** We currently have funding for 1FTE Clinical Nurse Specialist, 1FTE Clinical Nurse Consultant, 1FTE Registrar and 1FTE Project Manager. To fully implement this recommendation would require an expansion of the service given the growth in prison numbers.
19	An MOU is entered into to facilitate assessments for treatment orders as required	**Supported in principle** TPS have agreed to facilitate transfer of prisoners from Hobart Reception Prison to Risdon Prison Centre to facilitate assessments for Treatment Orders. We currently do not have a Consultant Psychiatrist in the north of the state to enable a similar process at Launceston Reception Prison.

20	Increased provision of mental health supports and services for prisoners in Reception Prisons	**Supported in principle** The FMHS supports the establishment of a mental health services for prisoners. This would require resourcing in addition to the resources currently available as described under recommendation 18.
21	Increased health staffing/resourcing for adult prisoners	**Supported in principle** Increased health staffing for adult prisoners would require additional resources given the growth in prisoner numbers.
22	Urgently increase TPS staffing resources to protect prisoners and staff	**Responsibility of another agency**
23	TPS and CPHS develop a designated inpatient unit for mental health presentations	**Supported in principle - Responsibility shared with another agency** TPS and CPHS have held discussions regarding a designated mental health inpatient unit. Depending on the model of care, this could require significant resourcing from both agencies.
24	Develop and engage with, best practice models which cater to the needs of the Tasmanian adult prison population	**Supported in principle** There is currently no dedicated Prison Mental Health Team (PMHT) within Tasmanian prisons. A PMHT would be a prerequisite for best practice models.
25	TPS encourage and support peer mentoring and embed in formal workloads	**Responsibility of another agency** TPS
26	Staff mental health training be embedded into onboarding and ongoing professional development frameworks	**Responsibility of another agency**

27	Reflective practice and other forms of peer supervision be integrated into workload for all staff	**Supported** Clinical supervision is provided to CPHS clinical leadership teams and this is currently being rolled out to all CPHS staff. In addition, performance and development discussions are scheduled annually for all staff with a focus on supporting employees: • to understand behaviour and performance expectations • to participate in two-way conversations with their manager about how they are going with their work and any development needs. The Department of Health Performance Policy and supporting resources detail a number of principles and requirements for having performance discussions, including what they must cover, how often they should occur and what documentation is needed.
28	Consider recruiting a staff member in Mary Hutchinson Women's Prison to the MATES framework	**Responsibility of another agency** TPS
29	Support TPS staff requests for training from mental health staff to increase mental health literacy, interdisciplinary learning and more coordinated mental health support for prisoners	**Responsibility of another agency** TPS
30	A psychologist with specific knowledge and skills related to gang and terrorism behaviour continues to work with TPS in a consultant role to develop methods to manage prisoners posing a risk to others	**Responsibility of another agency** TPS

31	Development of a structured, standardised and integrated system to assist in record management for offender mental health data	**Supported** In November 2023 CPHS transitioned from Prison Health Pro (a stand-alone database) to the iPM / DMR clinical databases. These are the systems used across Statewide Mental Health Services and enable CPHS to share information on offender mental health with other services, including Wilfred Lopes Centre, Adult Community Mental Health Services, Child and Adolescent Mental Health Services and Emergency Departments at general hospitals.
32	Existing policies are reviewed and updated to ensure that the mental health and wellbeing needs of staff working in a complex extreme and unusual environment typified by exposure to potentially traumatic events are appropriate to the context	**Responsibility of another agency** The mental health and wellbeing of CPHS staff are supported by Statewide Mental Health Service and Tasmanian Health Service policies. These are regularly reviewed and updated in line with the Department of Health policy framework
33	Develop and review governance structures to better account for mental health and wellbeing needs of staff and prisoners as a matter of priority, ensuring these reviews are workloaded appropriately to ensure meaningful engagement and associated outcomes	**Responsibility of another agency**
34	Implement a formal professional development framework in RPC to support implementation and consolidation of evidence-based, contemporary practices relating to therapeutic climate and therapeutic jurisprudence	**Responsibility of another agency**
35	Health staff liaise with correctional staff to ensure that mental health screening and monitoring is considered as part of the dry cell management procedure	**Supported - Responsibility shared with another agency** CPHS staff currently review prisoners under Dry Cell management on a daily basis.

36	As a matter of priority, develop policy or documentation regarding the management of the mental health needs of older and very old prisoners	**Supported in principle** Statewide Mental Health Services have policies and protocols in place to manage the specific mental health needs of older people for example assessment and management of acute behavioural disturbance.
37	Adopt early intervention models of mental health care	**Supported in principle** The implementation of a prisoner mental health service would facilitate early intervention model for mental health care. See response to Recommendation 18.
38	Additional resourcing of existing research units/engaging with partners to undertake robust targeted mental health research focused on custodial contexts	**Supported in principle - Responsibility shared with another agency** See response to Recommendation 18.
39	Identify and implement evidence-based/evidence-informed targeted intervention programs of shorter duration for prisoners within the RPC serving sentences of shorter duration	**Responsibility of another agency**
Physical health care and substance use management		
1	TPS and Correctional Primary Health Services (CPHS) develop a set of principles for the delivery of healthcare services and monitor their services against these principles.	**Supported - Responsibility shared with another agency** The Letter of Intent between CPHS and TPS and its appendices outline the principles for delivery of healthcare. This Letter of Intent is currently under review.
2	If prison lockdowns are urgently required for regular training, they occur a maximum of one day per month.	**Responsibility of another agency**
3	During prison lockdowns, each prisoner who is confined to their cell is considered to be in a state of segregation.	**Responsibility of another agency**

4	Prisoners in segregation have at least one hour out of their cell every day in line with the *Corrections Act 1997* and international humanitarian obligations.	**Responsibility of another agency**
5	People who are mentally ill are not subject to segregation unless it is by a specific order, such as disciplinary segregation or medical segregation.	**Responsibility of another agency**
6	People in segregation should be medically reviewed according to international guidelines.	**Supported in principle - Responsibility shared with another agency** Prisoners in segregation for disciplinary reasons are not currently medically reviewed daily by a medical practitioner or Registered Nurse. They do however have the opportunity to speak with a nurse during medication rounds which occur twice daily. CPHS will work with TPS to implement European Rules 43.2 and 43.3. This may have resource implications for CPHS.
7	CPHS staff receive the appropriate training to be permitted to walk within the maximum and medium security parts of the prisons unaccompanied.	**Supported - Responsibility shared with another agency** Currently only Psychiatric Liaison Nurses are permitted to walk, unescorted between maximum and medium units. CPHS will work with TPS to expand this provision to appropriate CPHS staff.
8	CPHS ensure appropriate standards relating to waiting times to see doctors are set and audited in a rolling cycle.	**Supported** CPHS was using Prison Health Pro information system until November 2023. This system was unable to accurately identify waiting times for appointments. Since November 2023 CPHS has transferred clinical documentation to iPM/DMR. These systems will now enable auditing of waiting times.

9	The business case for expansion of the available staff base with the opening of Southern Remand Centre (SRC) is reviewed and resubmitted.	**Responsibility of another agency**
10	Staff on workers compensation considered to be permanently incapacitated should be removed from the TPS staffing establishment to enable recruitment into their vacant full time equivalents (FTEs).	**Responsibility of another agency**
11	TPS and the unions are both encouraged to reach agreement about staff numbers required to fully operate the prison and the threshold for when lockdowns are required on the basis of staff shortages.	**Responsibility of another agency**
12	TPS Senior Management Team (SMT) seeks external advice from a management consultant regarding the development of a change management process to replace the command and control culture into a more contemporary and effective management approach.	**Responsibility of another agency**
13	TPS SMT seek external advice from a strategic human resources management consultant regarding the development of an effective staff recruitment and retention strategy.	**Responsibility of another agency**
14	The Director of Corrective Services considers granting prisoners in segregation during lockdowns special management days to the equivalent time they have been in lockdown and that this time is remitted from their sentence.	**Responsibility of another agency**

15	Training be provided for correctional staff about the role of health staff and vice versa.	**Supported - Responsibility shared with another agency** CPHS is supportive of additional training for TPS staff on the role of health staff.
16	Review the Letter of Intent between the Department of Health and the Department of Justice, and this to be shared with all staff from CPHS and TPS.	**Supported - Responsibility shared with another agency** The Letter of Intent is currently under review and will be shared with all staff on completion.
17	TPS to bring all standard operating procedures and Director's Standing Orders relating to healthcare services up to date and keep them under review.	**Responsibility of another agency**
18	CPHS Clinical Speciality group needs to meet at least six times per year.	**Supported** CPHS CSG did meet quarterly, i.e. 4 times per year but following Inspectorate recommendations, the CPHS Clinical Specialty Group now meets bi-monthly i.e. six times per year.
19	CPHS acknowledge patients' medical requests and give a date by when they will be actioned or reasons why they will not.	**Supported** The Moodle system has been introduced in certain parts of the prison whereby prisoners are able to make requests or enquiries to health via electronic communication. By utilising this system CPHS are able to acknowledge the request immediately and advise of progress on the complaint or request. It is hoped this system will be extended throughout the prisons.
20	Alert patients of their medical appointments without announcing it to the entire unit.	**Responsibility of another agency**

21	CPHS acknowledge the receipt of complaints and provide a date by which they will be investigated and if appropriate, actioned.	**Supported** The Department of Health Complaint and Feedback management policy, updated in April 2023, requires acknowledgment of all complaints within five working days and a response provided to the complainant within thirty-five working days.
22	Feed findings from complaints into the Clinical Speciality Group for introduction into the clinical improvement process.	**Supported** Complaints are included on CPHS Clinical Speciality Group (CSG) agenda.
23	CPHS to establish a regular meeting with the Health Complaints Commissioner to discuss complaints, trends and outcomes.	**Supported** CPHS leadership team last met with the Health Complaints Commission (HCC) in September 2023. At this meeting it was agreed to schedule regular meetings going forward. The Statewide Mental Health Service complaints team have regular communication with HCC on individual issues.
24	All CPHS health staff need access to peer support and supervision, training, skills and career develop opportunities, cultural diversity training, and regular updates in clinical practice.	**Supported** All CPHS staff are required to complete a range of training, both on commencement and through regular updates. This includes training in cultural awareness, patient centred care and clinical practice. Staff also have access to performance development through their managers.
25	Provide more shaded areas to the yards in the SRC.	**Responsibility of another agency**
26	Review the terms of reference, including operation and membership, of the Use of Force Review Panel with the view to increase community input, including the Tasmanian Aboriginal community.	**Responsibility of another agency**

27	Provide, as a minimum, the Dedicated Response Team (DRT) and officers working with watch-house detainees with body cameras.	**Responsibility of another agency**
28	Obtain prisoner perspectives after every use of force so they can be fed back into the review of the incident.	**Responsibility of another agency**
29	Review the violence reduction strategies that are in use to ensure they are contemporary.	**Responsibility of another agency**
30	The State Government to consider how people on workers compensation can access the psychiatric care they require.	**Responsibility of another agency**
31	Consider how best to support people on workers compensation or sick leave, especially in light of the Wellbeing Officer role no longer being funded.	**Supported - Responsibility shared with another agency**
32	Consider increasing nursing staff on duty in Hobart Reception Prison (HRP), as is done with correctional officers, during evenings and nights when there are public events likely to involve large crowds and substance use which may result in high numbers of arrests	**Supported in principle** Additional resources will be required to enable achievement of the recommendation
33	The medication management committee/ drugs and therapeutic committee should ensure all aspects of prescribing practice are in accordance with an established set of clinical guidelines for prescribing in correctional settings. Prescribing guidelines need to be developed where these differ from community treatment guidelines. A formulary needs to be agreed with clinicians.	**Supported** A CPHS formulary is available to Medical Officers for use specifically within Tasmanian prisons.

34	All medication changes made at the point of admission (and thereafter) should be discussed with the patient before they are made. Until then drugs prescribed in the community should be continued unless contraindicated; wherever possible community health providers should be contacted for treatment information, and proposed changes discussed.	**Supported** If medication needs to be changed from what the client was prescribed in the community, this would be discussed with the Medical Officer and entered into the clinical notes record. Certain medications are not prescribed in prison due to the risk of trafficking or the risk to the client from fellow prisoners. In these circumstances an alternative medication is prescribed as appropriate.
35	Electronic prescribing is established	**Supported in principle** Electronic prescribing has been identified as part of a long term solution to medication management within the correctional environment. This will form part of the EMR project due to be completed 2026.
36	Historical paper medication charts should be moved and stored off site in a central location.	**Supported in principle** Third party storage provider costs would need to be considered.
37	The policy and practice regarding drug availability in imprests in various sites should be reviewed and standardised and brought into accordance with Tasmanian pharmaceutical regulations. If pharmacy input is required at Launceston Reception Prison (LRP) this should be organised.	**Supported** Completed. The policy and practice regarding drug availability in imprests in various sites was reviewed and standardised and brought into accordance with Tasmanian pharmaceutical regulations.
38	Commonly required medication should be available in imprests to avoid gaps in medication administration.	**Supported** Nurse Initiated Medications are able to be administered by Registered Nurses without the need for a prescription.
39	Evening medication rounds should be established particularly for sedating or psychotropic medication.	**Supported in principle** Additional resources may be required to enable achievement of the recommendation

40	A multi-agency review of medication security should be undertaken with a view to enhancing it where possible, so reducing the potential for trafficking of medication and therefore increasing the use of medication that is therapeutically useful but deemed trafficable.	**Supported - Responsibility shared with another agency**
41	The use of on-person medication be reviewed.	**Supported** Weekly Webster medication pack are issued at Ron Barwon Prison. The use of on-person medication in other areas of the prison to be reviewed.
42	Over the counter medication should be more readily available in the units. TPS and CPHS should work to establish an effective policy to implement this.	**Supported in principle**
43	CPHS consider creating a list of medication that nurses across the prisons are permitted to dispense both with, and without, a prescription.	**Supported** Nurse Initiated Medications are able to be administered by Registered Nurses without the need for a prescription.
44	Medication be sent with prisoners to court with personal belongings as a matter of routine.	**Supported**
45	The post release medication practices should be reviewed and at least one week's medication should be sent with prisoners who are attending court or who are being released.	**Supported**
46	The criteria for access to dental care should be reviewed to include all patients, both sentenced and remandees, who meet the clinical criteria for care and they should be screened against these criteria by staff trained in dental triage.	**Supported - Responsibility shared with another agency** To be reviewed in consultation with Oral Health Services Tasmania.

47	CPHS should work with Oral Health Services to review and amalgamate the correctional and community waiting list to ensure people are not disadvantaged regarding their waiting times for dental treatment by virtue of changes to their custodial or legal status.	**Supported - Responsibility shared with another agency** To be reviewed in consultation with Oral Health Services Tasmania
48	Dentistry services at the prison need to be doubled without delay.	**Supported - Responsibility shared with another agency** OHST have been approached to consider utilising both dentistry suites at RPC and RBP. It was suggested, due to demand, that this could be for a trial period or until waiting list was shortened.
49	CPHS to review input provided by allied health professionals and business cases prepared to increase input to meet demand where necessary.	**Supported in principle**
50	Upgrade and mend the broken fittings in the Inpatients Unit.	**Supported in principle - Responsibility shared with another agency** Additional resources may be required to enable achievement of the recommendation
51	Refurbish the areas of the old Inpatients Unit.	**Supported - Responsibility shared with another agency** Additional resources required to enable achievement of the recommendation
52	Review TPS and CPHS staffing of the Inpatients Unit, particularly the reallocation of TPS staff to other areas during lockdowns.	**Supported - Responsibility shared with another agency**

53	Review the use of the Inpatients Unit, the medical procedures that could and should be undertaken there, and deliver appropriate training to staff as soon as practicable to reduce the number of escorts to hospital.	**Supported** A Clinical Nurse Educator has collaborated with clinicians from the Royal Hobart Hospital to provide in-reach training for CPHS staff.
54	Review the security needs of the Inpatients Unit to allow immediate medical access to all rooms.	**Supported - Responsibility shared with another agency**
55	Review the use, function and infrastructure of the Crisis Support Unit (CSU) to ensure it is a therapeutic space.	**Responsibility of another agency**
56	Increase number of medical escorts to hospital back to 8 per day without delay. This will take some work regarding resourcing, but it should be a priority.	**Responsibility of another agency**
57	CPHS and TPS work with Royal Hobart Hospital (RHH) to plan the implementation of secure areas in the refurbished Emergency Department so they can be used by prisoners and escorting staff.	**Supported in part - Responsibility shared with another agency** Meetings and discussions have commenced with Royal Hobart Hospital on this issue.
58	Develop a Memorandum of Understanding (MOU) with RHH and Launceston General Hospital (LGH) regarding mutual expectations and ways of working with prisoners to ensure their safety and welfare as well as that of the public. The MOU with RHH and LGH should also consider introducing regular visits of specialists to the prisons.	**Supported in principle** Additional resources may be required to enable achievement of the recommendation.
59	Review arrangements regarding escorts. Consider outsourcing of the transport function to an external provider while TPS is unable to staff the function to sufficient levels.	**Responsibility of another agency**

60	CPHS to liaise with TPS staff in good time regarding escorts required.	**Supported - Responsibility shared with another agency**
61	Increase use of video-conferencing and telehealth for healthcare, wherever possible, with outpatient clinics to minimise escorts required.	**Supported** Discussions are underway between TPS, CPHS and external health providers to maximise the use of Telehealth when a face to face appointment is unnecessary.
62	Review the level of information and support required regarding the management of menopause and related symptoms.	**Supported** A female Medical Officer provides dedicated services at Mary Hutchinson Women's Prison.
63	Incorporate the Volunteers for Change program into the male estate and into the CPHS clinical governance program.	**Supported - Responsibility shared with another agency** Additional resources required to enable achievement of the recommendation
64	TPS reintroduce the peer support service into Mary Hutchinson Women's Prison (MHWP).	**Responsibility of another agency**
65	Develop Alcohol and Other Drug (AOD) rehabilitation services for women to reflect their level of need.	**Supported - Responsibility shared with another agency** Additional resources required to enable achievement of the recommendation
66	Mental health input to the MHWP may require review. An audit of need should be conducted and the input provided should reflect the level of assessed need.	**Supported**
68	TPS and CPHS should conduct a recruitment drive targeted towards Aboriginal and Torres Strait Islander people.	**Supported - Responsibility shared with another agency**

69	CPHS should ensure that culturally appropriate care is provided to people from Aboriginal and Torres Strait Islander communities.	**Supported** A Medical Officer currently works between CPHS and Tasmanian Aboriginal Centre. In addition, the Statewide Mental Health Service Improving Aboriginal Cultural Respect within our Services Action Plan 2021 – 2024 outlines the services commitment to meeting the needs of people from Aboriginal and Torres Strait Islander communities. Staff are also required to complete Aboriginal cultural awareness training.
70	The need for transitional case management needs to be reviewed given the impact it can have on recidivism. Transitional case manager positions should be created and a manager appointed.	**Supported in principle** See response to Recommendation 18.
71	Assistance to those with disabilities to complete the requisite forms for services should be provided.	**Supported**
72	TPS and CPHS establish protocols to ensure prisoners have appropriate access to voluntary assisted dying.	**Supported - Responsibility shared with another agency** There is also a collaborative agreement in place between the Palliative Care in Prisons (QUT) and DoH. It has been managed in conjunction with the DoH Research Governance Unit.
73	Evaluation of the effectiveness of criminogenic programmes, especially in relation to substance use management, should be undertaken.	**Responsibility of another agency**
74	An alternative base for the Programs Team should be found so they are not accommodated in prison cells.	**Responsibility of another agency**

75	Criminogenic programs, especially those containing information about substance use management, should be reinstated within the prison service. They should be closely linked to community services, and ideally straddle delivery of program services in the community after the participant's release.	**Supported - Responsibility shared with another agency** Work is underway for CPHS to collaborate with the Alcohol and Drug Service (ADS) to improve substance use management and treatment.
76	Criminogenic programs, especially those containing information about substance use management, should be available to women when required.	**Supported - Responsibility shared with another agency** Work is underway for CPHS to collaborate with ADS to improve substance use management and treatment.
77	Review the policy regarding supports provided for tobacco cessation to ensure the humane treatment of those dealing with nicotine addiction and withdrawal.	**Responsibility of another agency**
78	Improve conditions within the dry cell, which is used to house prisoners suspected of internally concealing contraband, including installation of a call button and increasing frequency of levels of observation.	**Responsibility of another agency**
79	Increase screening of staff, contractors and visitors on entry and at random (including drug testing).	**Responsibility of another agency**
80	Base AOD waiting lists on all those who require the service, not on legal status. Use this waiting list to assist making the case for development of AOD services.	**Supported - Responsibility shared with another agency**
81	Deliver AOD treatment to people who require it rather than limiting treatments to those for whom community services are being allocated.	**Responsibility of another agency** CPHS and ADS have expanded treatment for prisoners requiring AOD treatment.

82	Review policy and protocols regarding management of alcohol and drug withdrawal to ensure adequacy of care.	**Supported - Responsibility shared with another agency** CPHS & ADS
83	Include therapy as part of the opiate replacement program as per treatment guidelines.	**Supported - Responsibility shared with another agency** Additional resources required to enable achievement of the recommendation.
84	Review criteria for placement on Opioid Replacement Therapy (ORT).	**Supported** Additional resources required to enable achievement of the recommendation
85	The leadership and structure of the delivery of AOD services is reviewed to ensure it is fit for purpose, contemporary and meets the needs of the prison population.	**Supported - Responsibility shared with another agency** Additional resources required to enable achievement of the recommendation

86	Parameters of eligibility for all AOD treatments and programs need to be created which reflect patient need. Criteria based purely on legal parameters (e.g. remand status) should be abolished. Waiting lists should be then used where necessary to demonstrate service insufficiency. Adequate support and clinical supervision for AOD staff, including off site support where required, should be structured into the program and fully funded to enable all treating staff to have sufficient access as part of the role. a) A space be identified for the delivery of a residential AOD therapeutic program pending the outcome of the business case for development of Division 8 in Ron Barwick Prison (RBP). Suitable prisoners should be identified for the program, moved to this area and the program initiated without delay. Whilst the program could be structured around the principles of Pathways, it needs multidisciplinary input and close integration with community AOD services, and with community services. Any carefully generated culture needs maintenance, or it can erode over time and this reduces program effectiveness. b) Custodial and therapeutic staff for this unit should be carefully selected. c) The effectiveness of the program should be evaluated.	**Supported - Responsibility shared with another agency**
87	Develop a business case for the establishment of an adequate number of AOD counsellor positions.	**Supported** Additional resources required to enable achievement of the recommendation

88	Introduce bleach needle-washing facilities and/or introduce needle exchange facilities.	**Supported in principle - Responsibility shared with another agency** Senior Management Team, the TPS leadership committee have approved this recommendation but work is still underway to implement this.
89	AOD services deliver a range of education programs to CPHS staff and TPS staff regarding drug use in prison and treatment approaches	**Supported in principle - Responsibility shared with another agency** Additional resources may be required to enable achievement of the recommendation
90	Develop a multi-agency interdisciplinary model of care for AOD service provision which extends into the community and uses the services of community providers who have contracts or Service Level Agreements (SLAs) to deliver coordinated services.	**Supported in principle - Responsibility shared with another agency** Additional resources required to enable achievement of the recommendation

Adult health care inspection report 2023

Appendix 7

Progress on previous Custodial Inspector recommendations

Office of the Custodial Inspector Tasmania

Contents

Progress made against previous physical health care & substance use management recommendations

Prior to the physical health care and substance use management inspection, the Custodial Inspector (CI) requested Tasmania Prison Service (TPS) and the Department of Health (DoH) provide an update of progress made against recommendations made in the 2017 Care and Wellbeing Inspection Report. The progress made against these recommendations according to the responsible agency, the CI's analysis of this progress at the time of inspection (January 2023) and our assessment of current status of the recommendation (at the time of inspection) are presented in the tables below. All recommendations made as a result of the 2017 Care and Wellbeing Inspection and the initial response to these recommendations from TPS and DoH are available from www.custodialinspector.tas.gov.au/inspection_reports

Table 1: Progress on recommendations made to Tasmania Prison Service.

All updates were provided by Tasmania Prison Service in January 2023 unless stated otherwise.

CI recommendation	TPS updates	CI analysis	Status
51. Improves access to prisoners for Correctional Primary Health Services staff.	Non-escorted access to CPHS staff is facilitated so long as deemed appropriate through risk assessments in order to ensure prisoners medical or related appointments and consultations are appropriately facilitated.	Access to CPHS staff may have been improved since the 2017 care and wellbeing inspection through the facilitation of non-escorted access to some prisoners. However, access to health services remained a primary concern of prisoners across all facilities. Additionally, Dr Petch highlighted the access to healthcare as a key issue in his report.	In progress
52. Introduces a process to enable prisoners to return medical request forms directly to the health clinic whilst maintaining confidentiality.	TPS notes that prisoners are able to lodge confidential medical request forms daily in each facility, or more frequently if required.	Prisoners are able to lodge medical request forms confidentially or deliver them straight to CPHS staff during medication rounds.	Complete
53. Introduces an awareness campaign to encourage prisoner patients to provide more detail on	TPS developed a communication strategy, in consultation with CPHS, to increase prisoner awareness of the	No concerns arose during the inspection except to the extent that prisoners referred to	Complete

CI recommendation	TPS updates	CI analysis	Status
the medical request forms so that nurses can triage effectively.	need to provide more detail on the medical request forms. This included regular instructions in the fortnightly prisoner newsletter to encourage prisoners to provide more detail on CPHS medical request forms.	not receiving responses to medical requests. This is addressed in Dr Petch's report.	
54. Introduces measures to assist prisoners that are illiterate and cannot complete a medical request form.	Existing processes allow for a range of options for prisoners with lower literacy levels including, forms in easy read English, forms with diagrams and opportunities to communicate directly with nurses to receive assistance in completing medical forms.	As described by TPS, the existing process allows for a range of abilities. Additionally, some prisoners with disability have another prisoner who acts as a support worker who can assist them with forms if necessary. Dr Petch has nonetheless made a recommendation that *assistance to those with disabilities to complete the requisite forms for services should be provided* and has noted that relying on carers, who may be a fellow prisoner, is not very confidential.	In progress
55. Undertakes a work safety audit in the Mary Hutchinson Women's Prison health clinic.	**[DoH]** Regular WH&S reviews of area are undertaken. Reviews will continue as normal practice.	Work, health and safety at the Mary Hutchinson Women's Prison health clinic was not raised as a concern during this inspection.	Complete
56. Reviews the physical layout of the Ron Barwick Minimum Security Prison health clinic to ensure there is an exit door in the clinic.	Not actioned; significant budget constraints	No action.	No action
57. Ensures that proper and detailed consideration is given to the specific high needs of the	**[DoH]** Redeveloped infrastructure within Division 7, Clinic Deputy now placed in RBP to provide direct	Dr Petch raised concerns about support provided to prisoners living with disability or who require additional assistance in his report.	In progress

CI recommendation	TPS updates	CI analysis	Status
increasing number of elderly, frail and disabled prisoners in prison forward planning. Consideration should be given to including a geriatric nurse on staff.	support to both CO & nursing staff as required. ADON meets with Prisoner carers once per month. Item parked as anything further would require significant funding through budget process.	Additionally, Professor Norris raised concerns regarding mental health support for old and very old prisoners.	
58. Ensures that prisoners have access to the immediate supply of EpiPens where there is a documented life threatening allergy.	**[DoH]** Issuing of EpiPens not considered suitable in prison environment (unless specified by Doctor). Resuscitation bags, which are taken in response to all incidents, includes adrenalin. Medical emergency procedures are to be applied and appropriate precautionary measures applied for treatment of allergies.	My 2017 Care and Wellbeing report stated, *'… EpiPens are not available for use across any of the facilities. The feedback from registered nurses was strongly that EpiPens should be available for, and used by, prisoners with anaphylactic allergies, as they are in the community.'* The Department's response would appear to go against the principle of equivalence to the non-offender. My team did not test response times for medical emergencies during our recent inspection. Minutes, however, can be critical in the event of severe anaphylaxis and so any action plans for anaphylaxis for prisoners should carefully consider, in consultation with TPS, what options are available to ensure timely access to EpiPens for those most at risk.	No action
59. Considers implementing procedural changes to provide timely access to Paracetamol after hours for prisoners.	**[DoH]** Matter previously reviewed with takeaway Panadol now available to prisoners in suitably determined accommodation (RBP and Vanessa	As outlined in Dr Petch's report, many prisoner complaints are related to poor pain management. Despite the ability to contact nursing staff 24 hours a day for consideration	In progress

CI recommendation	TPS updates	CI analysis	Status
	Goodwin Units). Review of process in Medium RPC to occur in future. Established process for prisoners to contact nursing staff 24 hours a day for consideration of issuing paracetamol.	of issuing paracetamol, many prisoners raised issues regarding access to paracetamol after hours with the inspection team during the inspection. Relevantly, there are no nurses on night shift stationed at reception prisons and we spoke with one prisoner who said he had severe COVID-19 symptoms during the night whilst at HRP but was told he had to wait till the morning to access paracetamol. Dr Petch has expanded on this recommendation, stating that over the counter medication, such as simple analgesics like paracetamol, should be more readily available in units.	
60. Reviews and implements changes to the strip searching process for hospital escorts to improve the process and reduce strip searching of prisoners.	The review identified that robust personal search procedures are in place to maintain the security and good order of prisons and meet legislative and local procedural requirements. The introduction of body scanners in early 2023 will significantly reduce the need to undertake personal searches.	This recommendation should be completed with the introduction of body scanners in 2023.	In progress
61. Until access to all health services for most prisoners is ensured, minimises escorts for private medical consultations in order to reduce lock downs which disadvantage many others and	Private medical consultations are required for procedures not undertaken by CPHS in prisons – for example, specialised dental, optical and hearing appointments. TPS will not interfere with a prisoner's access	TPS rationale not to apply this recommendation appears to be valid.	No action required

CI recommendation	TPS updates	CI analysis	Status
result in diminished treatment time in the prison clinic.	to health services where their condition requires treatment, including by external medical agents.		
62. Provides all prisoners unhindered access to condoms and lubricant.	This currently occurs across all TPS prisons, noting that restrictions remain in place across the maximum rated units. **MHWP:** • Dental Dams are supplied by CPHS and are placed in the Dr/Nurses waiting room for collection (at leisure), CPHS maintain supply. • Women access the waiting room in AM and PM at medication parade times. • Alternatively they could be provided by Correctional Staff upon request. • Wellington would be upon request only. **RBP:** • Dental dams are not supplied. • Condoms are available from a vending machine on the workshop front.	During multiple visits the Custodial Inspector team has noted that condoms and lubricant were not always available in the outlets in SRC and RBP. Restrictions in maximum units do not equate to unhindered access. TPS has raised concerns about condoms being used to traffic drugs but this should not restrict prisoners from being able to protect themselves from sexually transmitted infections.	In progress

CI recommendation	TPS updates	CI analysis	Status
	RPC: • Dental dams are not supplied. • Condoms are replaced frequently through the maintenance team to any units with dispensers, which includes all of Medium Security and all of SRC. • Maximum security units do not have dispensers and can be supplied on request if appropriate. **Reception Prisons:** • Dental dams are not supplied. • Condoms are available on request from nursing staff. It is noted that condoms are commonly used within the prison to secrete contraband.		
63. Reviews, risk assesses and considers introducing a needle exchange for prisoners given the high transmission rate of blood borne viruses in the Tasmanian prison system.	While the intent of this recommendation is understood, it is a complex issue that may interfere with re-offending behaviour that rehabilitative programs are working hard to address. Further exploration of this issue indicates that this action is not widely supported across custodial centres in Australia. Drug	A lack of support for needle exchange programs in other custodial centres in Australia should not prevent their implementation here. TPS has a chance to become an Australian leader and reduce harm to prisoners and to the community to which they will return. Dr Petch's report outlines the benefits of these programs and has again reiterated the need for	No action

CI recommendation	TPS updates	CI analysis	Status
	and Alcohol programs are provided to those prisoners who require them.	a needle exchange program or needle cleaning programs.	
64. Ceases the process of requiring nursing staff to maintain a sharps register in health clinics.	TPS requires the use of a sharps register to ensure accountability relating to the use of dangerous items in a prison environment in locations that are also frequented by prisoners. This is a safety measure to protect both prisoners and staff.	My 2017 Care and Wellbeing report stated, '*… in all health clinics there is a requirement for CPHS staff to maintain and complete a sharps register, whereby every needle is accounted for. The external medical consultant considered that the practice of maintaining a sharps register is disruptive, distracting and does not protect staff safety. Nor does a sharps register form an integral part of sharps management as it can be easily defrauded. The inspection found the sharps registers appeared to be an unregulated system and, at one site, staff were not maintaining a register. Whether a sharps register is being maintained or not, sharps do need to be consistently secured and the inspection found that this was the case in all health clinics.'* TPS' commitment to maintaining what was in 2017 an anecdotally flawed register appears to place form over substance.	No action
65. Undertakes a review of the medical chit process, with consideration given to the division of responsibilities between TPS and Correctional Primary Health	This review has occurred with division of responsibilities identified and changes implemented.	No significant issues with the chit process were raised with the inspection team.	Complete

CI recommendation	TPS updates	CI analysis	Status
Services, and implements changes to improve the process.			
116. Makes available an equivalent alcohol and drug treatment program, such as the Apsley Unit, for women prisoners.	The Dialectical Behavioural Therapy commenced in MHWP on 7 June 2021 and facilitate targeted holistic support for women, including drug and alcohol programs.	Limited information was found regarding alcohol and drug treatment programs available to women during the inspection. Dr Petch's report highlighted several limitations / issues with the current alcohol and drug services and programs available throughout the prison facilities. The alcohol and drug treatment program in the Apsley Unit is no longer provided.	In progress
117. Advises prisoners that the full impact of smoking substances other than tobacco, such as dried vegetable and plant matter, is unknown and that smoking these products may be addictive and inhaling smoke-based products or substances is harmful to the lungs and respiratory system.	A reoccurring feature article was included in the prisoner newsletter by the Safer Prisons Senior Officer.	This recommendation has been appropriately actioned.	Complete
118. Introduces a separate dosing area for the pharmacotherapy program to improve access for prisoners to medical services provided by Correctional Primary Health Services in the clinic area.	The response to this recommendation has been overtaken by the transition to Buvidal Depot Injections.	This recommendation no longer appears to be relevant due to the transition to Buvidal Depot Injections.	No action required

CI recommendation	TPS updates	CI analysis	Status
119. Considers introducing a secure accommodation area for those prisoners undergoing treatment in the pharmacotherapy program.	The response to this recommendation has been overtaken by the transition to Buvidal Depot Injections.	This recommendation is no longer relevant due to the transition to Buvidal Depot Injections.	No action required
120. Facilitates an independent review of the Department of Health and Human Services state-wide community, and TPS, Alcohol and Drug models of care.		Information was provided during the inspection regarding the Alcohol and Drug Services (ADS) review of the AOD Model of Care (MOC). This project was in the early stages, involving preliminary discussions with stakeholders, and a Steering Committee to be formed next.	Unknown
121. Facilitates an independent appraisal of the pharmacotherapy program noting the need, the integrity of any program, and the appropriate policies and procedures that should underpin an agreed program.	**[DoH]** New Buvidal administration process is being lead in the prison for Tasmania, which is the most contemporary process available. Review is occurring by Drug and Alcohol Services to implement in the community.	Unclear from DoH comments whether the Drug and Alcohol Services review will be published and/or used for service/policy improvement. It was highlighted during the inspection that the number of prisoners able to access the pharmacotherapy program is limited by the number of places available in the community to ensure continuity once prisoners are released.	In progress
122. Reviews the current line management / administrative supervision arrangements for Alcohol and Drug Counsellors, noting that external clinical supervision and formal peer supervision has ceased.	**[TPS]** This recommendation was referred to DoH **[DoH]** The Drug & Alcohol Clinical Nurse works in conjunction with TPS IOM staff / Drug and Alcohol Program Officers for improved services to clients.	Issues related to lack of support and clinical supervision of Alcohol and Drug Counsellors, TPS employees, were raised with the inspection team. These are noted in Dr Petch's report and similar recommendations are again made.	In progress

Table 2: Progress on recommendations made to Correctional Primary Health Services (CPHS).

All updates were provided by the Department of Health in January 2023 unless stated otherwise.

CI recommendation	DoH updates	CI analysis	Status
66. Seeks a rotation from Royal Hobart Hospital and Launceston General Hospital of a Junior Resident Medical Officer to assist with burgeoning workloads of CPHS Medical Officers.	Currently under consideration by CPHS - to review in 6 months' time with progress update.	Awaiting update	In progress
67. Develops a nurse-based workforce that reflects the diverse health needs of the complex client group (i.e. not all generalist nurses), specifically mental health and drug and alcohol nurses.	Recent work on this to ensure diversity of nurses improved, with 4 x Clinical Nurse Consultants in place with diverse skills and a CNC Liaison position that works with Alcohol & Drug Services. Will continue to recruit and retain nurses with diverse skills	The planned establishment of a prisoner mental health service within CPHS should also result in further development of the workforce.	In progress
68. Enters formal arrangements with the Aboriginal Community Controlled Health Organisations in the south and north of the State, or recruits Aboriginal Health Workers to the service.	State-wide Mental Health Services have commenced pilot program in conjunction with TAS Aboriginal Service. TPS is part of the pilot program. Update to be provided in 6 months	Awaiting update	In progress
69. Explores with TPS the funding and commissioning of a radiology suite on the Risdon campus.	**[DoH]** Services are accessed through RHH and LGH which is determined suitable and where treatment can also	There are understandable reasons why this recommendation has not been actioned but practical solutions should be considered to	No action

CI recommendation	DoH updates	CI analysis	Status
	be provided. Would require significant funding if progressed, in addition to appropriate resources / training to ensure appropriate interpretation of scans. **[TPS]** This recommendation is supported in principle, however has significant budgetary implications which are assessed through normal budget processes.	reduce the need for medical escorts to RHH and LGH for radiology appointments where possible and appropriate.	
70. Explores with TPS the funding and commissioning of a physiotherapy suite on the Risdon campus.	Physiotherapist currently has a space to provide services to prisoners, however there is no identified area (or need at this time) for a physiotherapist gym. Review in 2 years to determine needs.	As stated in Dr Petch's report, the physiotherapist is currently on site once per month, which does not reflect demand. A review may need to be undertaken sooner than the 2-year timeframe to determine whether an increase in visit frequency is warranted and if the current physiotherapy space is suitable.	No action
71. Reviews the governance for pharmacists, with a view to changing the structure so that the pharmacists report directly to a senior pharmacist.	This is currently the case as per reporting structure		Complete
72. Introduces the community-accepted standard for medication management, which is to allow medications to be provided to	Current practice in suitable accommodation. Review of process in Medium RPC to occur in future	This practice currently occurs in Ron Barwick Prison. The date for the review to occur in relation to Medium RPC has not been	In progress

CI recommendation	DoH updates	CI analysis	Status
prisoners, where it is appropriate, on a weekly basis.		specified. When it occurs, it should review the feasibility more broadly, including MHWP.	
73. Ensures that all medications distributed to prisoners are signed for by nursing staff contemporaneously to distributing the medication.	The process of medication administration is approved by an Independent Accreditation Agency. Continue to review for continual improvements in process.	During the inspection there was some evidence to indicate that this was not happening, and that the only way to know medication had been given to prisoners was that the Webster pack had medications popped out of the pack.	In progress
74. Ensures that when a prisoner refuses a regular order, the appropriate notation is made on the prisoner's medication chart	This is part of the medication administration process and always recorded.	No issues with these processes were raised during this inspection.	Complete
75. Reviews the processes relating to blood tests taken as part of the admission screen/assessment and implements changes to ensure that this screening does not cease during busy periods.	The admission screening process has been strengthened with identified tests undertaken and reviewed.	No issues with these processes were raised during this inspection.	Complete

Table 3: Progress on recommendations made to Tasmania Prison Service and Correctional Primary Health Services.

All updates were provided in response to the Custodial Inspector's request in January 2023. The source of the update is stated in the table.

CI recommendation	TPS / DoH updates	CI analysis	Status
76. Review the responsibility and processes for cleaning of the Inpatients facility to ensure adequate and timely sanitation and infection control.	**[DoH]** Review undertaken and CPHS has advised that a contracted cleaner is employed to clean inpatients facilities and that further training would be provided.	No issues were raised regarding the cleanliness of the inpatients facility during the inspection.	Complete
77. Consider options for implementing an appropriate forum to improve communications and discuss and resolve issues on a regular basis.	No evidence was provided.	Monthly meetings occur between CPHS and TPS management but during the inspection communication channels were demonstrated to be poor at the operational and management level as evidenced by the TPS refusing entry of a CPHS medical officer without any consultation with CPHS. This incident, however, resulted in subsequent improvements to communications. Improvements in processes will need to be documented.	In progress

Progress made against previous mental health care recommendations

Prior to the mental health care inspection in June 2022, the Custodial Inspector (CI) requested Tasmania Prison Service (TPS) and the Department of Health (DoH) provide a range of documentation relating to the mental health care inspection standards. The CI did not specifically ask for an update of the progress made against the mental health care recommendations made in the 2017 Care and Wellbeing Inspection Report. Evidence on progress made against these recommendations has been compiled from documentation and written submissions supplied from TPS and DoH. This evidence, as well as the CI's analysis of this progress at the time of inspection (June 2022) and their current status (at the time of inspection) are presented in the tables below. All recommendations made as a result of the 2017 Care and Wellbeing Inspection and the initial response to these recommendations from TPS and DoH are available from www.custodialinspector.tas.gov.au/inspection_reports

Table 4: Progress on recommendations made to Tasmania Prison Service.

All evidence was obtained from Tasmania Prison Service documentation and written submissions provided in June 2022 unless stated otherwise.

CI recommendation	TPS Evidence	CI analysis	Status
78. Considers establishing a mental health leadership position for the prisons to provide oversight, strategic planning, and coordination of mental health services (e.g. Director of Mental Health Services). This position should work closely with the existing medical director of the Correctional Primary Health Service.	The reporting structure for prisoner mental health services as of 23/05/2022 was to be confirmed	This leadership position does not appear to have been established. However, there does seem to be some development in the mental health space. Briefing by Department of Health at the beginning of the Mental Health Inspection (June 2022) indicated the establishment of Prison Mental Health Service Steering Committee and commitment to development of a Prison Mental Health Service under Forensic Mental Health Service governance	No action

CI recommendation	TPS Evidence	CI analysis	Status
79. Establishes and identifies dedicated spaces that are conducive for the provision of mental health care in the prisons.	The Mersey Needs Assessment Unit is dedicated to accommodating prisoners who are identified as needing additional support at the beginning of their incarceration, increased behavioural support for those with cognitive impairment or other neurally-diverse presentations, those who at increased risk of suicide and self-harm, or who are perceived as being vulnerable due to their age and/or functioning.	Dr Sonny Atherton, Statewide Speciality Director, Forensic Mental Health Service (FMHS), addressed this issue at page 5 of his submission to the Legislative Council Government Administration Committee 'B' Inquiry into Tasmanian Adult Imprisonment and Youth Detention Matters, dated 31 March 2023[1]. He said that despite Professor Ogloff's recommendation in the CI 2017 report and despite the recent expansion of the Risdon Prison Complex there remains no dedicated area in the prison suitable to support prisoners with mental health issues who do not meet the criteria for admission to the Wilfred Lopes Centre. Although therapeutic support is provided to prisoners housed in Mersey and the Crisis Support Unit (CSU) the actual infrastructure of these units remains stark and untherapeutic. Professor Norris identified that the existing infrastructure was inadequate to meet demand and highlighted the need for the space to be made more therapeutic in her report. These	No action

[1] Parliament of Tasmania, 2023 Legislative Council Sessional Committee Government Administration B Inquiry into Tasmanian Adult Imprisonment and Youth Detention Matters, *Submission 46 – Tasmanian Health Service*, available from: https://www.parliament.tas.gov.au/__data/assets/pdf_file/0035/69848/46.-Tasmanian-Health-Service.pdf

CI recommendation	TPS Evidence	CI analysis	Status
		sentiments were echoed by Dr Petch in his report. This recommendation cannot be considered to have been met given both our consultants' observations and the Statewide Speciality Director of FMHS comments.	
80. Considers the training needs of prison officers to identify, communicate, and deescalate prisoners with mental illnesses. Based on the prison officers' needs, a training package should be developed and delivered.	Therapeutic Services provides training to all new recruits including: • suicide and self-harm • a brief mental health package • a brief vicarious trauma, resilience and trauma informed practice workshop Other training by the Therapeutic Services to stakeholders is conducted on an as-needs basis. The TPS continues to develop a Trauma Informed Framework and relevant policies / procedures, and is endeavouring to seek funding for a dedicated Trauma Informed Practice Manager.	Professor Norris reported that many correctional officers recognised the value of the training that they received through TPS. Correctional officers provided feedback that training in early identification of declines in prisoner mental health and wellbeing was desired. Professor Norris further recommended that staff mental health training be embedded into onboarding and ongoing professional development frameworks. The establishment of a Trauma Informed Practice Manager would potentially provide significant improvements towards meeting the needs of prisoners.	In progress

Table 5: Progress on recommendations made to Correctional Primary Health Services.

All evidence was obtained from Department of Health documentation and written submissions provided in June 2022 unless stated otherwise.

CI recommendation	DoH Evidence	CI analysis	Status
81. Commences planning immediately to meet the need for additional dedicated mental health professionals to work in the prisons. Service levels should be modelled on existing and anticipated demand, taking into consideration the developing national standards.	**[DoH]** Forensic Mental Health Services (FMHS) provide the following professional supervision of the mental health service workforce within TPS through: 1.0 FTE Statewide Speciality Director CPHS 1.0 FTE Statewide Speciality Director FMHS 1.0 FTE Clinical Nurse Consultant Co-Morbidity CPHS 1.0 FTE Locum Psychiatrist FMHS 0.3 FTE Psychiatric Registrar 1.0 FTE Psychiatric Liaison Nurse A business case was submitted on the 23 March 2021, which was approved by the Deputy Secretary Community Mental Health and Wellbeing on 26 May 2021 for an additional 13.54 FTE of Mental Health Staff.	In the 2017 Care and Wellbeing Inspection Report, the Mental Health Consultant suggested that TPS could be expected to have approximately: 0.6 FTE psychiatrists 21.6 FTE mental health nurses 2.3 FTE psychologists - at the Risdon site alone. Dr Atherton noted in his submission to the Legislative Council Committee, referenced above, that the business case from May 2021, although approved, was not funded. He went on to say that the recommendation of the Custodial Inspector cannot be met at this time. Professor Norris also raised ongoing staffing shortages across all contexts (correctional, non-correctional and health staff) as an issue in her report. Until the approved business case is funded it is unlikely the Department will be able to comply with this recommendation.	In progress

CI recommendation	DoH Evidence	CI analysis	Status
	[TPS] Therapeutic Services in comprised of the following staff: 1.0 FTE Senior Psychologist 4.0 FTE Psychologist 1.0 FTE High Needs Support Counsellor – Disability 4.0 FTE High Needs Support Counsellor This is a total of 10.0 FTE with 1.0 additional FTE funded by other part time positions. However, due to vacancies and extended leave only 6.3 FTE is currently occupied.		
82. Includes in strategic planning for mental health services workforce development, professional development, and succession planning to ensure growth and stability of the workforce overtime.	As above	As above Strategic direction 9 in Rethink 2020 A State Plan for Mental Health in Tasmania 2020-2025 is about supporting and developing the mental health workforce.	In progress
83. Considers formalising the mental health screening by using a dedicated and validated mental	CPHS undertake an initial Tier 1 Health Assessment screening within 24 hours of a person's reception into	CPHS are not using a dedicated mental health form or requiring qualified mental health nurses to undertake this screening.	No action

CI recommendation	DoH Evidence	CI analysis	Status
health screening form, and engaging qualified mental health nurses to conduct the mental health screening, separate to the general health screening assessment.	custody. This is conducted by Senior Registered Nurses (General and Mental Health).		
84. Reviews the process and content of their approach to triaging prisoners with mental illness, in order to move towards a more systemic and formalised approach.	**[TPS]** Processes are being put in place to arrange for a centralised point for referrals and a triage system.	No issues with these processes were raised during this inspection.	In progress

Table 6. Progress on recommendations made to Tasmania Prison Service and Correctional Primary Health Services.

All evidence was obtained from Tasmania Prison Service and Department of Health documentation and written submissions provided in June 2022. The source of the information has been acknowledged in the table.

CI recommendation	TPS / DoH Evidence	CI analysis	Status
85. Consider establishing a service agreement with the Forensic Mental Health Services for the provision of psychiatric services.	**[DoH]** Forensic Mental Health Services provides 1.0 FTE psychiatrist and 0.3 FTE psychiatric registrar who provide support for patients requiring specialist psychiatric input, typically indicated by the presence of serious mental disorder or complex needs which exceed that which would ordinarily be provided at the primary health level.	This increased staffing is a positive development, which will be further strengthened if the business case from 2021 for additional staff is funded. The increased staffing is, however, uncertain. Dr Atherton's specifies in his written submissions, referenced above, at page 5 that "A number of mostly 'ad hoc' resourcing measures have been taken in an effort to improve mental health services to prisoners. The major improvement has been the dedication of a full time psychiatrist to prison. That is currently an 'unfunded position'. …Both the FMHS nurse and psychiatric registrar have been taken from elsewhere in the FMHS; that is, those resources must be forgone by another part of the FMHS and are not formally dedicated to prison mental health. It is unlikely the FMHS can support this ongoingly, given other service demands." Given the inherent uncertainty and ad hoc nature of the funding, it could not be said that this recommendation has been completed.	In progress

CI recommendation	TPS / DoH Evidence	CI analysis	Status
86. Give further consideration to the structure and role of mental health professionals. The development of a multidisciplinary team with clear roles in the assessment, treatment, and monitoring of prisoners with mental illnesses is required.	**[DoH]** CPHS conduct weekly multidisciplinary team (MDT) meetings, where Therapeutic Services attend to discuss client plans, discharge, and treatment options. Meeting minutes are circulated between services.	As outlined in Professor Norris' report, MDT meetings are being held and staff reported them to be a reasonable compromise to the issues raised by the mental health taskforce. However, health staff and staff in the Therapeutic Services Unit identified a range of governance structures that required development and review during the mental health inspection. Therefore there is work to be done to further develop the structure and roles of the mental health teams.	In progress
87. Undertake planning for a dedicated mental health unit within the prison to serve as a step down facility: a. for prisoners returning from hospitalisation; and b. to assist in managing and providing treatment to prisoners who require dedicated mental health care but do not meet the requirements for involuntary hospitalisation in a secure forensic mental health facility	**[TPS]** The Mersey Needs Assessment Unit is dedicated to accommodating prisoners who are identified as needing additional support at the beginning of their incarceration, increased behavioural support for those with cognitive impairment or other neurally-diverse presentations, those who at increased risk of suicide and self-harm, or who are perceived as being vulnerable due to their age and/or functioning.	Although therapeutic support is provided to prisoners housed in Mersey and the Crisis Support Unit (CSU) the actual infrastructure of these units remains stark and untherapeutic. Professor Norris identified that the existing infrastructure was inadequate to meet demand and the need for the space to be made more therapeutic in her report. These sentiments were echoed by Dr Petch in his report.	In progress
88. Develop a community integration program to identify and bridge prisoners with mental	**[DoH]** Protocols around handover and transfer of care for patients entering and exiting prison aligning	These improved protocols / policies did not appear to be in place. Additionally, Professor Norris identified that increased provisions for	In progress

CI recommendation	TPS / DoH Evidence	CI analysis	Status
illnesses to appropriate community mental health services when preparing for their release.	with Statewide Mental Health Service policies are in development. Currently, prisoners with clinically significant mental illness are discussed at an interdisciplinary meeting and as far as possible, plans to transfer care to appropriate community-based supports are made. Aspects of this process are problematic, and this is a central item to be addressed in PMHS [Prisoner Mental Health Services] service development.	reintegration planning and support will be needed to address the diverse and increasingly complex mental health needs of prisoners transitioning into the mainstream community following release from prison.	

Table 7. Progress on recommendations made to Tasmania Prison Service, Correctional Primary Health Services, and Forensic Mental Health Services (FMHS).

All evidence was obtained from Tasmania Prison Service and Department of Health documentation and written submissions provided in June 2022. The source of the information has been acknowledged in the table.

CI recommendation	TPS / DoH Evidence	CI analysis	Status
89. Work together to model service demand to help identify the nature and extent of mental health services and capacity required now, over the short term and longer term, to meet the needs of prisoners with mental illnesses	**[TPS]** The current demand forecasting model does not include mental health service demand.	No evidence was seen of any modelling by TPS or DoH.	No action

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