Australian Women's Health Alliance

Thought Leadership Series

Out of Sight: The Health of Incarcerated Women

Key messages

- Women are the fastest-growing group of Australia's prison population. The number of women in prison rose by 12% in the year to June 2025, and almost half (48%) of those women are First Nations.
- Most incarcerated women are victim-survivors of trauma and violence, yet people in prison are excluded from Medicare, leaving their mental health, reproductive health, disability and continuity-of-care needs largely at the discretion of corrections authorities funded by State and Territory governments.

Purpose of this brief

Australian Women's Health Alliance works to articulate the policies and actions necessary to improve health outcomes for women and gender diverse people. The purpose of this brief is to put a gender lens on the health of women in custody and how current policies and practices potentially impact women's health equity.

Background

Women in prison are among the most medically and socially disadvantaged people in Australia. At 30 June 2025 there were 3,831 women in Australian prisons, an increase of 12% (399 women) in a single year. Of these women, 1,833 (48%) identified as First Nations.[1]

The pathways that lead women into prison are well documented. Between 70% and 90% of women in custody have experienced emotional, sexual and/or physical abuse, most often at the hands of an intimate partner.[2] Many women are held for short periods or on remand; in one Western Australian study, nearly half of prison stays among mothers of infants lasted 2 weeks or less.[3] Each period in custody disrupts housing, employment, parenting and healthcare, while doing little to address the trauma, poverty and ill health that underlie offending.

National policy formally recognises this group. The National Women's Health Strategy 2020–2030 names women and girls affected by the criminal justice system as a priority population, noting that female prisoners on average have poorer health and show signs of ageing 10 to 15 years earlier than the general population.[4] However, this recognition occupies only a small section of the Strategy and has not been matched by a dedicated, funded national response.

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[1] Australian Bureau of Statistics, Prisoners in Australia, 2025, ABS, Canberra.

[2] ANROWS (2020) Women's imprisonment and domestic, family and sexual violence: Research synthesis, Australia's National Research Organisation for Women's Safety, Sydney.

[3] Dowell CM, Mejia GC, Preen DB & Segal L (2018) 'Maternal incarceration, child protection, and infant mortality: a descriptive study of infant children of women prisoners in Western Australia', Health & Justice, 6(2).

[4] Australian Government Department of Health (2018) National Women's Health Strategy 2020–2030, Canberra, p. 15 and p. 24.

This brief summarises the evidence on the health of incarcerated women in Australia, drawing on published research and insights from a frontline practitioner who has worked directly with incarcerated women, predominantly First Nations women, in Queensland. It sets out policy recommendations across trauma, self-determination, reproductive health, continuity of care, disability and accountability.

The Problem: Unmet Health Needs Behind Bars

Over-representation of First Nations women

First Nations women are among the most incarcerated populations in the world and have been described as Australia's fastest-growing prison population. The Australian Law Reform Commission found that Aboriginal and Torres Strait Islander women were imprisoned at 21.2 times the rate of non-Indigenous women, and at a higher rate than non-Indigenous men.[5] They are also 15.7 times more likely than non-Indigenous women to be held on remand while awaiting trial.[6]

The trend is worsening. Closing the Gap Target 10, to reduce the over-representation of First Nations adults in prison, is going backwards: the adult imprisonment rate reached 2,500 per 100,000 in 2025, 16.7 times the non-Indigenous rate, with tougher bail laws nationally identified as a key driver.[7]

Trauma as a pathway into prison

Between 75% and 90% of incarcerated First Nations women have been victims of sexual, physical or emotional abuse, most experiencing multiple forms.[8] Research shows that violence creates pathways into the justice system, through substance use as a means of coping, through actions taken to escape violence (such as driving unlicensed), and through women fighting back to protect themselves. Trauma, mental ill health and housing instability resulting from violence then compound contact with police and courts.[9]

> **Practitioner insight:** *Pathways to prison are strongly linked to trauma and to worsening social conditions in women's lives. Any response that treats incarceration in isolation from this history will not change outcomes.*

Children and families

More than half (54%) of women entering prison have at least one dependent child.[10] Maternal incarceration shapes children's outcomes profoundly. A Western Australian linked-data study of 6,680 children found that children whose mothers had been imprisoned were 7 times more likely to

[5] Australian Law Reform Commission (2017) Pathways to Justice: Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples, ALRC Report 133.

[6] Australian Human Rights Commission (2024) Statistics about Aboriginal and Torres Strait Islander women and girls, drawing on ALRC (2017) Pathways to Justice.

[7] National Indigenous Times (18 March 2026) 'Closing the Gap: suicide, incarceration and child development targets go backwards', reporting Productivity Commission Closing the Gap data.

[8] ANROWS (2020) Women's imprisonment and domestic, family and sexual violence: Research synthesis, Australia's National Research Organisation for Women's Safety, Sydney.

[9] Ibid.

[10] Australian Institute of Health and Welfare (2020) The health and welfare of women in Australia's prisons, Cat. no. PHE 281, Canberra: AIHW.

experience substantiated maltreatment and almost 13 times more likely to enter out-of-home care.[11] Among infants whose mothers were imprisoned during pregnancy or infancy, around one in three were placed in out-of-home care by age 2, and infant mortality was more than double that of other children. Nearly half of these maternal prison stays lasted 2 weeks or less.[12]

Medicare exclusion and the secrecy of prison healthcare

Section 19(2) of the Health Insurance Act 1973 (Cth) has been applied to exclude people in prison from Medicare and the Pharmaceutical Benefits Scheme, on the basis that state and territory governments provide health care in custody.[13] As a result, the scope, quality and timeliness of care are at the discretion of corrections authorities, rather than being anchored to the standards and accountability of the community health system. The 2024 National Review of First Nations Health Care in Prisons identified Medicare exclusion, poor access to care, failures of medication management and poor continuity of care on transition to the community as longstanding problems.[14]

> **Practitioner insight:** *Because all healthcare is delivered at the discretion of corrections, there is a culture of secrecy around what care women receive. Families, advocates and community health providers often cannot see whether basic needs are being met.*

Mental health

Mental health needs are the largest and least addressed area of health need for women in custody. In 2025, 93% of female prison entrants had at least one current health condition recorded, and 48% of women had active mental health-related prescriptions, compared with 30% of men. Around one-third of all prison entrants report a history of self-harm.[15] Despite this, trauma-informed and gender-responsive mental health treatment in custody remains limited.

Disrupted continuity of care

Entry into custody frequently interrupts treatment that women were receiving in the community. Opioid agonist treatment (OAT) is a clear example: when methadone or buprenorphine is not continued on reception, women experience acute withdrawal and serious side effects, and their risk of overdose after release increases. A 2025 national consensus statement recommends that custodial health services continue OAT for people entering custody without interruption, and strongly recommends OAT for pregnant women given its benefits for antenatal care and birth outcomes.[16]

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[11] Segal L, Dawe S, Nguyen H, Dennison S, Gnanamanickam ES, Bell M, Spittal M, Kinner S & Preen DB (2023) 'Child protection system involvement in children of incarcerated mothers: A linked data study', Child Abuse & Neglect.

[12] Dowell CM, Mejia GC, Preen DB & Segal L (2018) 'Maternal incarceration, child protection, and infant mortality: a descriptive study of infant children of women prisoners in Western Australia', Health & Justice, 6(2).

[13] Health Insurance Act 1973 (Cth), s 19(2); Community Justice Coalition (2022) Medicare access for prisoners, Sydney.

[14] Nous Group (2024) The National Review of First Nations Health Care in Prisons (2023–24): Final Report, Australian Government Department of Health and Aged Care.

[15] Australian Institute of Health and Welfare (2026) The health of people in Australia's prisons 2025, Canberra: AIHW.

[16] Chan et al. (2025) 'National consensus statement on opioid agonist treatment in custodial settings', Medical Journal of Australia, 222(5).

Reproductive, sexual and menstrual health

Reproductive and sexual health, pregnancy care and menstrual health are significant unmet needs. Although the National Women's Health Strategy commits to expanding family planning services for incarcerated women, access to contraception, cervical screening and sexual health care in custody remains inconsistent.[17]

In 2025 the Queensland Inspector of Detention Services reported that women in the safety unit of the Southern Queensland Correctional Centre were not provided with tampons and were instructed to hold sanitary pads between their legs, with inspectors observing menstrual blood on women, their bedding and in their cells. The Inspector characterised these conditions as degrading.[18] This falls well short of the United Nations Bangkok Rules, which require that women in prison be provided with sanitary products free of charge.[19] Senator Lidia Thorpe is currently campaigning on the treatment of women in custody, including access to menstrual products, and in September 2026 introduced legislation to prohibit the shackling of women during childbirth.[20]

Pregnancy, birth and mothers and babies' units

Around 7 in every 100 women received into custody are pregnant.[21] Pregnant women in custody can apply to keep their baby with them in a mothers and babies ('mums and bubs') unit, but programs vary widely across jurisdictions, eligibility is restrictive and approvals can be slow. Evidence to the Yoorrook Justice Commission highlighted particular barriers for First Nations women, and without these programs newborns are typically separated from their mothers within days of birth.[22]

> **Practitioner insight:** *Applications to mothers and babies units are frequently denied. In South East Queensland, postnatal care for women who gave birth while incarcerated is very limited.*

Gender-affirming care

Trans and gender diverse people in prison experience disproportionate rates of harm, including poor mental health outcomes, and correctional policies on access to gender-affirming care vary substantially across Australian jurisdictions.[23] Where even basic health needs often go unmet in custody, access to gender-affirming care is especially precarious.

Incarcerated women with disability

Disability is a defining but largely invisible feature of women's imprisonment. In 2025, almost half (49%) of women entering prison reported a health condition or disability that limits their everyday

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[17] Australian Government Department of Health (2018) National Women's Health Strategy 2020–2030, Canberra, p. 15 and p. 24.

[18] Queensland Inspector of Detention Services (2025) Inspection report: Southern Queensland Correctional Centre; as reported in ABC News (20 March 2025) 'Southern Queensland Correctional Centre prisoners subject to degrading conditions, report says'.

[19] United Nations General Assembly (2010) United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), A/RES/65/229, Rule 5.

[20] Crimes Amendment (Prohibiting Shackling During Childbirth) Bill 2026 (Cth); The Guardian (CPA), 14 September 2026, 'Thorpe seeks to end shackling during childbirth'.

[21] Australian Institute of Health and Welfare (2023) The health of people in Australia's prisons 2022: Reproductive health, Canberra: AIHW.

[22] About Time (2025) '"Kids soften the jail": Keeping mums and kids together in prison', citing evidence to the Yoorrook Justice Commission.

[23] Dalzell L, Pang SC & Bromdal A (2024) 'Gender affirmation and mental health in prison: A critical review of current corrections policy for trans people in Australia and New Zealand', Australian and New Zealand Journal of Psychiatry, 58(1), 21–36.

activities, compared with 41% of men.[24] People with disability make up around 18% of the Australian population but almost half of people entering prison.[25] Cognitive and psychosocial disability, acquired brain injury and Fetal Alcohol Spectrum Disorder frequently co-occur with trauma, mental ill health and substance use, yet the Disability Royal Commission documented how disability is frequently unidentified throughout the criminal justice system.[26]

For First Nations women, disability compounds other disadvantage. Research tracking Aboriginal women with mental and cognitive disability through the New South Wales justice system found they were 3.7 times more likely than non-Aboriginal women in the same cohort to have been in out-of-home care as children, had their first police contact at a younger age, and had been in adult prison an average of ten times over their lives.[27] This is a pattern of repeated, short periods of custody in place of disability support in the community.

Prisons are rarely designed with disability in mind. Women who cannot understand or comply with rules may have disability-related behaviour treated as misconduct and punished, including through isolation. Human Rights Watch found that most prisoners with disability it interviewed had spent time in solitary confinement, and that sexual violence was 'ever-present in both male and female prisons'.[28] Many incarcerated women have never received a diagnosis and therefore have no NDIS plan or support. Divided Commonwealth and state responsibilities, reliance on self-reporting at reception, and the reluctance of NDIS-funded clinicians to accept referrals into custody mean that those with plans also face disrupted support, both in custody and on release.[29]

Current Policy Response and Landscape

The health of women in custody is acknowledged in the National Women's Health Strategy 2020–2030, but only in a small section identifying women and girls affected by the criminal justice system as a priority population.[30] There is no national framework setting minimum standards for women's health care in custody.

The National Review of First Nations Health Care in Prisons, published in December 2024, documented longstanding failures including Medicare exclusion and poor continuity of care.[31]

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[24] Australian Institute of Health and Welfare (2026) The health of people in Australia's prisons 2025: Health conditions or disabilities that affect everyday activities, Canberra: AIHW. Excludes Queensland.

[25] Human Rights Watch (2018) 'I Needed Help, Instead I Was Punished': Abuse and Neglect of Prisoners with Disabilities in Australia, New York: HRW.

[26] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023) Final Report, Volume 8: Criminal justice and people with disability.

[27] Indigenous Australians with Mental Health Disorders and Cognitive Disability in the Criminal Justice System (IAMHDCD) project, UNSW (2015) 'How Aboriginal women with disabilities are set on a path into the criminal justice system', The Conversation.

[28] Human Rights Watch (2018) 'I Needed Help, Instead I Was Punished', op. cit.

[29] Croakey Health Media (19 June 2024) 'What will it take to stop disabled people in prison falling between the cracks of services and systems?', National Network of Incarcerated and Formerly Incarcerated Women and Girls.

[30] Australian Government Department of Health (2018) National Women's Health Strategy 2020–2030, Canberra, p. 15 and p. 24.

[31] Nous Group (2024) The National Review of First Nations Health Care in Prisons (2023–24): Final Report, Australian Government Department of Health and Aged Care.

However, advocates have criticised the Review for not adequately addressing gender-specific and culturally appropriate health care for women, or barriers to NDIS access.[32]

At the state level, Queensland's Women's Safety and Justice Taskforce produced a substantial body of work on women and girls' experiences of the criminal justice system, including as accused persons and offenders. Its second report, *Hear her voice*, made 188 recommendations.[33] The Taskforce has since concluded, and there is a risk that its evidence base and momentum will be lost without ongoing oversight of implementation.

These are important foundations, but on current trends, with women's imprisonment rising and Closing the Gap Target 10 going backwards, the health needs of incarcerated women will continue to grow without more deliberate national action.

Policy Recommendations

1. Recognise trauma as a central driver

- Adopt trauma-informed, gender-responsive approaches across policing, courts, corrections and custodial health, recognising that most women in custody are victim-survivors of violence.
- Invest in diversion, bail support and non-custodial alternatives for women charged with lower-level offences, so that short periods of custody and remand do not further disrupt health, housing and parenting.
- Screen for domestic, family and sexual violence and trauma on reception, linked to specialist, culturally safe trauma recovery services in custody and after release.

2. Co-create solutions with First Nations women

- Ensure First Nations women, including women with lived experience of incarceration, lead the design, governance and evaluation of policies and services that affect them.
- Fund Aboriginal Community Controlled Health Organisations to deliver in-reach health care in women's prisons and to provide continuity of care on release.
- Develop gender-specific actions under Closing the Gap Target 10, recognising the distinct pathways and needs of First Nations women.

3. Guarantee reproductive, sexual, maternal and menstrual health

- Require all custodial facilities to provide free, adequate and unrestricted menstrual products, consistent with the Bangkok Rules, with dignified alternatives where safety concerns arise.
- Provide contraception, cervical screening, sexual health and blood-borne virus care, and antenatal and postnatal care equivalent to community standards.
- Legislate to prohibit the use of restraints during labour and birth.
- Establish a presumption in favour of mothers and babies placements, with transparent eligibility criteria, timely decisions, written reasons for refusal and public reporting of application outcomes.

[32] National Network of Incarcerated and Formerly Incarcerated Women and Girls (2024) 'National Review of First Nations Health Care in Prisons: A missed opportunity to address urgent issues'.

[33] Women's Safety and Justice Taskforce (2022) Hear her voice – Report Two: Women and girls' experiences across the criminal justice system, Queensland Government.

4. Ensure continuity of care on entry to and exit from custody

- Extend Medicare and PBS access to people in custody, including through ministerial exemptions under section 19(2) of the Health Insurance Act, so that care in prison is anchored to community standards.
- Continue existing medications and treatment, including opioid agonist treatment, mental health treatment and gender-affirming care, without interruption on reception, in line with the national consensus statement on OAT.
- Expand gender-responsive mental health services in custody and resource discharge planning that links every woman to a GP or Aboriginal Community Controlled Health Service before release.

5. Identify disability and secure NDIS access

- Introduce universal, culturally appropriate disability screening on reception, including for cognitive disability, acquired brain injury and Fetal Alcohol Spectrum Disorder, with a funded pathway to diagnostic assessment.
- Clarify Commonwealth and state responsibilities for NDIS supports in custody and enable NDIS applications to be lodged and fast-tracked before release.

6. Strengthen transparency and accountability

- Task the Australian Institute of Health and Welfare with regular national reporting on the health of women in custody, disaggregated by First Nations status and disability, including access to menstrual products and mothers and babies placements.
- Strengthen independent oversight of custodial health services, including through Australia's obligations under the Optional Protocol to the Convention against Torture (OPCAT).
- Expand the treatment of incarcerated women in the next National Women's Health Strategy and monitor implementation of the Queensland Women's Safety and Justice Taskforce recommendations.

What does this mean for health equity?

Incarcerated women, and particularly First Nations women, carry some of the heaviest burdens of trauma, ill health and disadvantage in Australia, yet they are among the least visible in health policy. Their exclusion from Medicare, the interruption of their care on entry to custody, and unmet needs in mental, reproductive, menstrual and disability health compound the harms that led them to prison and extend those harms to their children. Every woman in custody will return to the community. Health care in prison that meets community standards, is trauma-informed, and is designed with First Nations women is not only a matter of human rights; it is one of the most direct opportunities available to improve health equity for women and their families.

About us

Australian Women's Health Alliance provides a national voice on women's health. We highlight how gender shapes experiences of health and health care, recognising that women's health is determined by social, cultural, environmental, and political factors.

Contact us

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We acknowledge the Traditional Custodians of the lands and waters on which we live and work. We pay our respect to Elders past and present. Sovereignty has never been ceded.