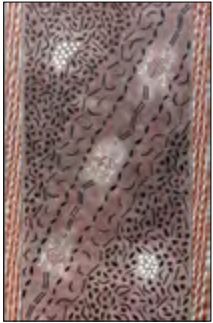




Keeping our mob healthy in and out of prison

Exploring Prison Health in Victoria to Improve Quality,
Culturally Appropriate Health Care for Aboriginal People





Front cover design: *Turtle Dreaming – Hunting and Gathering*

Date created: 2012

Artist: Dennis Thorpe - Muruwari | Kunja

Acrylic on canvas 108 x 68 cm

Identifying information: Brown, red, white and black acrylic paint on canvas. Three turtles on a diagonal path and two sets of turtle eggs. The painting has crosshatched borders and stencilled background.

Design description: We know the turtles in our area and understand their laying patterns. We know the areas where they lay their eggs but don't take them all. That way we know many turtles will be there next year. Each turtle lays ten eggs.

Note: The artist retains all copyright and moral rights attached to this image.

Artwork developed through The Torch - Statewide Indigenous Arts In Prisons & Community Program. The Torch engages Indigenous offenders and ex-offenders in art and cultural exploration that looks toward strengthening ties to Country, Culture, family history and community coupled with post release vocational support and professional development opportunities.

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Note on terminology: VACCHO acknowledges that although the terms 'Aboriginal' and 'Indigenous' have been used throughout this document, we are referring to both Aboriginal and Torres Strait Islander peoples in Victoria.

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1 Executive Summary

The prison health system presents an opportunity to improve Aboriginal prisoners' health and wellbeing, diagnose and treat health and mental health problems, and mitigate the effects of harmful behaviours. Improving prison health systems for Aboriginal people can also reduce high rates of post-release hospitalisation and mortality experienced by Aboriginal prisoners and improve quality of life.

Aboriginal prisoners experience higher rates of health and mental health problems than non-Aboriginal prisoners. The impact on prison health care is foreshadowed by consistent increases in the number of Aboriginal people imprisoned in Victoria each year. One in 33 Aboriginal males is imprisoned in Victoria at any one time, and the rate of overrepresentation is increasing for both Aboriginal men and women. More than 50% of Aboriginal people released from Victorian prisons return within two years, which places increasing importance on continuity of care.

With large numbers of Aboriginal people moving in and out of the prison system, a strong relationship should exist between prison health services and prisoners' community health and mental health provider. The 28 Aboriginal Community Controlled health Organisations (ACCHOs) and their auspiced organisations across Victoria are located within 55km of all Victorian prisons. ACCHOs are a critical extension of prison health care given Aboriginal prisoners access ACCHOs more frequently than mainstream services in the community. ACCHOs' comprehensive support and engagement of Aboriginal people plays a big part in improving quality of life and improving poor health and mental health outcomes by providing a holistic, healing health service.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO), with support from the Victorian Government Department of Justice, explored ways to improve continuity of care for Aboriginal people in Victorian prisons and identify ways to improve relationships and partnerships between ACCHOs and prison health services. ACCHOs, prison health services, and Koori support staff members from the Department of Justice were interviewed and their responses analysed for common themes.

We found no relationship or partnership between ACCHOs and prison health services interviewed despite policy references requiring it within the Justice Health Policy and Quality Framework (attached to the prison health services contracts). Responses also indicated that prison health service systems were not meeting cultural safety policy standards. ACCHOs identified several areas in need of improvement to assist Aboriginal prisoner health including prisoner release planning and the transfer of health information.

Given the low level of contact between ACCHOs and prison health services there were few working examples that could be shared. A list of recommendations based on interview responses, a literature review and exploration of non-Victorian models is presented as a first step in improving health and mental health outcomes for Aboriginal prisoners. An overview of recommendations is presented below (see the full list of recommendations in the next section):

Cultural Safety of Prison Health Services

- Increase access to Aboriginal health staff members
- Implement Reconciliation Action Plans at each prison health service
- Improve cultural awareness among prison health staff members

Improving Partnerships with ACCHOs

- Develop a transition health model for Aboriginal prisoners in collaboration with ACCHOs
- Develop formal partnerships with local ACCHOs
- Improve processes for unplanned prisoner release for example at court
- Improve health information exchange processes with ACCHOs
- Improve transition support processes for Aboriginal prisoners that have refused health care

Improving Prison Health Policy

- Increase Koori community representation on Clinical Advisory Committee
- Increase access to Aboriginal prisoner health and mental health statistics

Improving cultural safety in the prison health system and continuity of health and mental health care throughout imprisonment and release is critical to improving Aboriginal prisoner health and mental health. By increasing access to Aboriginal prisoner health and mental health data to inform service delivery and improving relationships, information exchange, and planning between ACCHOs and prison health services we expect to see improvements in health and mental health among Aboriginal people that extend to social, financial and other benefits to the wider Victorian community.

2 Recommendations

Cultural Safety of Prison Health Services

Recommendation	Agency/ies	Expected benefits
1 Increase involvement of Aboriginal Health Workers (or ALO/AWBO if no AHW is available) during prisoner reception	Prison health services, Justice Health	<ul style="list-style-type: none"> • Improve cultural safety • Decrease service barriers • Increase health service utilisation
2 Prison health services to implement and regularly audit Reconciliation Action Plans or similar systemic cultural safety plans (available on the Reconciliation Action Plan online hub) to increase prison health cultural safety. All prison health staff members to complete basic cultural safety training	Prison health services, Justice Health	<ul style="list-style-type: none"> • Increase health service utilisation • Increase diagnosis and treatment • Improve adherence to treatment
3 Increase opportunities for prison health workers to develop rapport with Koori prisoners. For example, one or more prison health workers could be nominated to regularly attend Koori prison programs and liaise with the ALO	Prison health services	<ul style="list-style-type: none"> • Increase health service utilisation • Increase diagnosis and treatment • Improve adherence to treatment
4 Offer placement opportunities in prison health services for training Aboriginal health professionals such as Aboriginal Health Workers and nurses	Prison health services, Justice Health	<ul style="list-style-type: none"> • Improve cultural safety • Increase Aboriginal staff members
5 Chronic disease management plans (and reviews) to include mandatory mental health and substance use-related prompts (utilising direct and indirect language) and a greater focus on referral to prison alcohol and other drug services to increase diagnosis and treatment and address the very high rates of these illnesses among Aboriginal prisoners	Prison health services, Justice Health	<ul style="list-style-type: none"> • Increase diagnosis and treatment • Reduce very high rates of mental health and substance abuse disorders
6 Report annually on Aboriginal prisoner health and compare to non-Aboriginal prisoners. Report should also include medications and type and frequency of presentations	Prison health services, Justice Health	<ul style="list-style-type: none"> • Improve planning and responsiveness of community-based services

Improving Partnerships Between Prison Health Services and ACCHOs

Recommendation	Agency/ies	Expected benefits
7 Develop a transition health model for Aboriginal prisoners to improve continuity of care and reduce hospitalisation among recently released Aboriginal prisoners	Corrections Victoria, Justice Health, Department of Health, prison health services, ACCHOs	<ul style="list-style-type: none"> • Reduce hospitalisation rates • Improve continuity of care • Increase health service engagement post-release
8 Establish processes to increase access and utilisation of Aboriginal prisoners' pre-prison health and mental health histories as early as possible. Ensure copies of prison health histories are provided to ACCHOs, the prisoner's preferred health provider and/or transition support workers whenever possible, with particular attention to 'between the lines' information in discharge summaries	Prison health services, ACCHOs, Justice Health	<ul style="list-style-type: none"> • Reduce retelling of personal histories • Improve continuity of care • Increase safety • Improve transition outcomes
9 Improve planning and transition support for prisoners released via parole and court as part of efforts to reduce recidivism, increase safety and reduce harm	Prison health services, Justice Health	<ul style="list-style-type: none"> • Improve transition outcomes • Improve continuity of care
10 Consider offering tenders to Aboriginal organisations to deliver culturally competent health services to Aboriginal prisoners	Prison health services, Justice Health, ACCHOs	<ul style="list-style-type: none"> • Develop cultural safety • Increase service utilisation • Improve continuity of care
11 Prison health services should develop relationships with the Koori community and ACCHOs as outlined in the Justice Health Policy and Quality Framework. Possible links include attendance at RAJAC/LAJAC meetings, and exploring the feasibility of a prison health-ACCHO network	Prison health services, Justice Health, ACCHOs, VACCHO	<ul style="list-style-type: none"> • Develop cultural safety • Improve transition outcomes
12 Develop a pre-release checklist specifically for Aboriginal prisoners, including a process that ensures Aboriginal prisoners that have a health need or have refused treatment in prison are provided with additional post-release support	Prison health services, ACCHOs	<ul style="list-style-type: none"> • Improve transition outcomes • Increase contact and improve relationship between prison health services and ACCHOs

13	Prison health services, ACCHOs and transition support agencies such as Konnect to discuss ways to improve release and transition processes	Prison health services, Justice Health, transition support agencies, ACCHOs Corrections Victoria	<ul style="list-style-type: none"> • Improve transition outcomes • Improve continuity of care
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14	Improve partnerships between Opioid Substitution Therapy-dispensing pharmacies, prison health services and ACCHOs and increase local access for Aboriginal prisoners post-release	Pharmacies, prison health services, ACCHOs	<ul style="list-style-type: none"> • Improve transition outcomes • Improve continuity of care • Address high levels of substance abuse disorders
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Improving Prison Health Policy

Recommendation	Agency/ies	Expected benefits	
15	Include representation from the Koori community on the Justice Health Clinical Advisory Committee	Justice Health	<ul style="list-style-type: none"> • Increase responsiveness to Aboriginal health needs
16	Increase the number of Aboriginal people working at Justice Health	Justice Health	<ul style="list-style-type: none"> • Increase cultural safety at policy level

3 Introduction

Aboriginal people remain consistently overrepresented in the Victorian and Australian justice systems (1–5). On 30 June 2011 more than a quarter of Australia’s prison population identified as Aboriginal and/or Torres Strait Islander (1). This reflects an age-standardised rate 14 times higher than non-Aboriginal people; practically unchanged since the Royal Commission into Aboriginal Deaths In Custody (RCIADIC) found an imprisonment rate 15 times that of non-Aboriginal people in 1991 (6). The number of Aboriginal prisoners in Victoria increased by 82% between 2006 and 2013, almost double the rate of non-Aboriginal prisoners (2,7). Aboriginal people represented 7.4% of Victorian prisoners in 2013 despite representing 0.9% at the time of the 2011 Census (7–9) Contact with the justice system is just one of a range of factors that encumber efforts to reduce the health and socio-economic gaps between Aboriginal and non-Aboriginal people.

Rates of tobacco use, alcohol and cannabis misuse, diabetes, and other health-related illnesses are worse among Aboriginal prisoners than non-Aboriginal prisoners (10,11). The impact on prison health care is foreshadowed by consistent increases in the number of Aboriginal people imprisoned in Victoria each year. This health system however, presents an opportunity to improve Aboriginal people’s health and wellbeing and reduce disease and harmful behaviours given Aboriginal prisoners across Australia¹ are less likely to have accessed healthcare outside prison than non-Aboriginal prisoners (10).

Present practice of prison health services must be strengthened and improved to ensure quality care is provided to a growing Aboriginal prison population with already poor health. One method proposed is greater utilisation of Aboriginal Community Controlled Health Organisations (ACCHOs) in prison health service delivery (6). ACCHOs are accessed by Aboriginal prisoners more than mainstream services (4), and offer a unique connection that benefits prisoners after their release.

This study focuses on prison health services in the adult prison system as well as their relationship with ACCHOs. Analysis, discussion and recommendations are based on interviews with seven health managers in Victorian prison health services, seven practice managers in ACCHOs as well as a group meeting of Aboriginal Wellbeing Officers and Aboriginal Liaison Officers employed by Corrections Victoria. The study aimed to examine what processes are in place for Aboriginal people in contact with the Victorian prison health system, how ACCHOs are utilised, and how the systems can best work together. The project was funded by the Justice Health unit and the Koori Justice Unit within the Victorian Government Department of Justice.

1 Excluding Western Australia

4 Background

4.1 Imprisonment rates of Aboriginal and Torres Strait Islanders

More than 80,000 people were sentenced in Victorian courts between 1 July 2010 and 30 June 2011, overwhelmingly (90%) in the Magistrates' Courts (12). Although there are a lack of detailed statistics in Victoria due to a systemic non-identification of Aboriginality during justice-related processes (12), overrepresentation is likely to mirror high incarceration rates and the experience of other jurisdictions. In Queensland and Northern Territory Magistrates' Courts, 20% and 72% of defendants respectively identified as Aboriginal or Torres Strait Islander between 1 July 2010 and 30 June 2011 (12). Males make up more than 90% of Aboriginal prisoners – a crude imprisonment rate of approximately 170 per 10,000 people compared to Aboriginal women at 17 per 100,000² (13).

The number of Aboriginal prisoners in Victoria has increased by 82% since 2006, almost double the rate of non-Aboriginal prisoners (2,7). Seven years ago 215 Aboriginal people represented 5.8% of Victorian prisoners (2); that number has now surpassed 390 – or 7.4% – of Victorian prisoners (7). Aboriginal people are not only 10 times more likely to be in prison, they are also more likely to return to prison than non-Aboriginal people, with at least one in two returning within two years and 77% having a previous imprisonment (7,14) Aboriginal prisoners serve shorter sentences, however are more likely to be in maximum security prisons and less likely to be in minimum security prisons (7,13).

Correction orders in Victoria have changed recently however the number of Aboriginal people on Community Correction Orders (previously Community Based Orders) has increased to 898 in 2013 – 7.3% of all correction orders (7,13). The completion rates of these orders in the past 10 years oscillated between 50 and 60 per cent for supervised orders and 65 and 80 per cent for unsupervised orders (13).

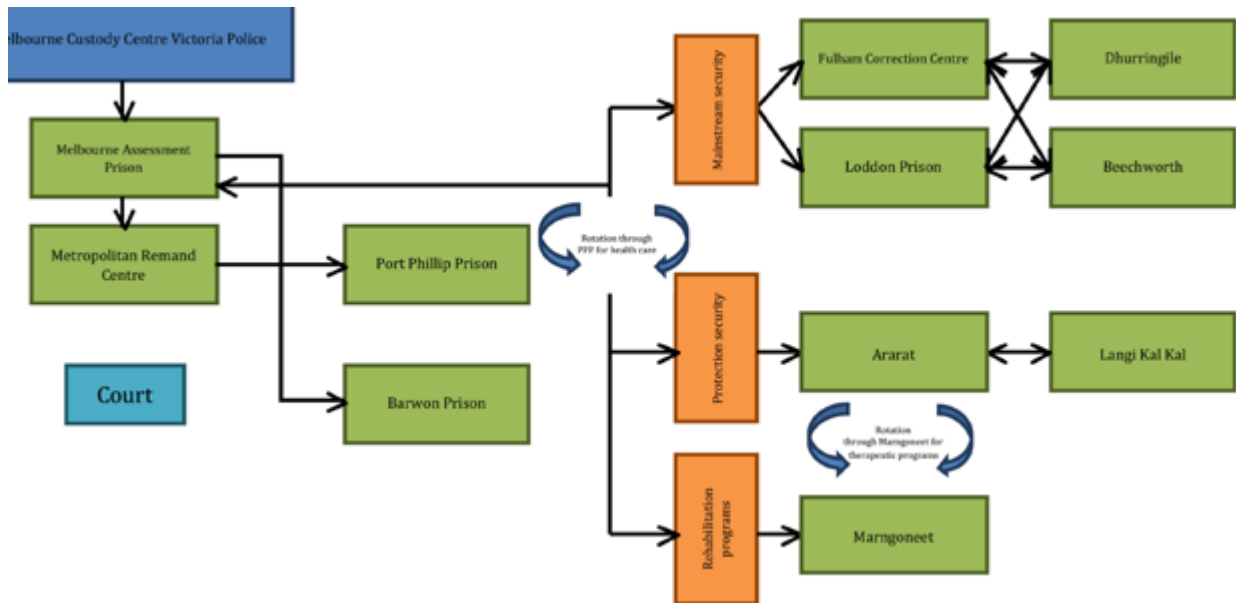
Young Aboriginal and Torres Strait Islanders were 22.7 times more likely to be in juvenile detention than non-Aboriginal young people in 2009; an increase of 55.2% between 2001 and 2009 compared to 14.4% for non-Aboriginal young people (5). Young Aboriginal and Torres Strait Islanders are also more than 14 times more likely to be under juvenile justice supervision than non-Aboriginal young people on any day (15). Aboriginal young people experience high rates of justice contact throughout Australia representing 30%, 36% and 83% of defendants in the Children's Courts of New South Wales, Queensland and the Northern Territory respectively (12). The Victorian Government Department of Human Services is responsible for young people in juvenile detention, however these figures suggest a large cohort of young Aboriginal people could move into the Victorian Government Department of Justice-controlled adult prison system in years to come.

4.2 Victoria's prison health system

There are 13 prisons and one transition centre in Victoria, all of varying capacity, security, and prison population. Victorian prisons are publicly owned and operated by the Department of Justice with the exception of Port Phillip Prison and Fulham Correctional Centre. All prison health services are contracted out to a mix of private and public sector health providers under contract with the Victorian Department of Justice for public prisons and G4S Australia Pty Ltd and GEO Group Australia Pty Ltd at Port Phillip and Fulham respectively. Prison health care is delivered by three health providers: GEO Care (all prisons except Port Phillip Prison), St Vincent's Correctional Health Service (Port Phillip Prison), and Forensicare (mental health section of Melbourne Assessment Prison).

² 2011 gender ratios for Aboriginal people were not released at the time of writing and are instead based on 2006 Census counts

Figure 1: Victoria's prison system



Source: Adapted from Justice Health presentation (unpublished).

The Justice Health unit within the Department of Justice sets policy and standards and manages public prison health provider contracts. Planning is overseen by a Joint Management Committee (JMC) consisting of the Department of Health, Justice Health, Corrections Victoria and Victoria Police. A clinical advisory committee advises Justice Health and the JMC on best practice, policy, patient safety, and quality and clinical leadership.

4.3 Aboriginal Community Controlled Health Organisations in Victoria

Aboriginal Community Controlled Health Organisations have a proud history as sustainable, democratic, grassroots organisations that assist in building community capacity for self-determination and direct provision of community services. ACCHOs view cultural identity as part of their strength as representatives of the Aboriginal community. ACCHOs seek to assist every Aboriginal person realise their full potential as a human being and as a member of their community. All Victorian ACCHOs recognise the Aboriginal view of health as defined by the National Aboriginal Community Controlled Health Organisation (NACCHO):

Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life (16).

All Victorian ACCHOs meet the requirements of NACCHO, which defines an ACCHO as an incorporated Aboriginal organisation, initiated by a local Aboriginal community, based in a local Aboriginal community, governed by an Aboriginal body elected by the local Aboriginal community, and delivers a holistic and culturally appropriate health service to the community which controls it (17).

VACCHO's 23 members and four associate members are all community owned, managed and delivered ACCHOs. These services and their auspiced organisations across Victoria are a critical part of Aboriginal health care. These culturally safe, holistic services extend from prenatal to aged care with some ACCHOs having their own psychologists, psychiatrists, podiatrists, and other allied health workers. Social support services such as housing and Centrelink assistance, men's, women's and elder's groups, childcare, family counselling and more address the determinants of health that are critical to improving people's wellbeing. ACCHOs' comprehensive support and engagement of Aboriginal people plays a big part in improving quality of life and improving poor health and mental health outcomes by providing a holistic, healing health service.

ACCHOs are located within 55km of all Victorian prisons. Figure 2 and Figure 3 below illustrate the geographical distribution of ACCHOs and prisons across Victoria.

Figure 2: Victorian ACCHOs and prisons



Figure 3: Metropolitan ACCHOs and prisons



4.4 Health of Aboriginal people in prison

Compared to Aboriginal people in the community, rates of tobacco, alcohol and cannabis, methamphetamines, and pain killer use are higher among Aboriginal prisoners across all age groups (4). Aboriginal prisoners self-report poorer health than non-Aboriginal prisoners and are less likely to have accessed healthcare outside prison (4,11), and are also more likely to have high blood sugar and diabetes, elevated liver-disease markers, asthma, and other health-related illnesses (4,11). Aboriginal prisoners use more tobacco, alcohol, cannabis and methadone than non-Aboriginal prisoners (4,11).

Rates of blood borne viruses such as hepatitis B and C and sexually transmitted infections such as chlamydia, gonorrhoea, and syphilis are much higher among Aboriginal and Torres Strait Islander people (18,19). Hepatitis C is particularly worrying among Aboriginal prisoners. A survey of needle-dispensing pharmacies in New South Wales found that Aboriginal people were much more likely to have been in prison in the last year than non-Aboriginal clients. They were also more likely to share injecting equipment and possessed less knowledge of the virus (20). The prevalence of Hepatitis C is likely to increase among prisoners, with rates rising among Aboriginal people aged 20-29 years (19).

Given the short average sentences of Aboriginal prisoners (13), the consequences of high rates of sexually transmitted infections and blood borne viruses are likely to reach beyond the prison walls. Longer treatments (Hepatitis C for example) are longer than many prison sentences for example, and require long term coordination among multiple health service providers (21). Making sure prisoners receive continuity of care when entering prison, being moved within the prison system and released from prison will reduce the incidence of subsequent infections.

Being released from prison has become the most dangerous time for Aboriginal prisoners, marked by high mortality and hospitalisation (22–25). Significantly elevated rates of suicide, motor vehicle accidents, circulatory system diseases and drug-related death are present in the first four weeks, and even first year of release (22,23,25). Rates of survival among male and female Aboriginal prisoners in the first year of their release are lower than non-Aboriginal prisoners (22).

Aboriginal prisoners also have much higher rates of mental health problems than the general community and non-Aboriginal prisoners. The 12 month mental illness prevalence among Aboriginal prisoners in Queensland was 73% among males and 86% among females (26). This compares to 20% among the general population and 41% among non-Aboriginal prisoners (27). Substance use and affective disorders were the most prevalent form of mental illness, with rates of substance misuse 13 times greater among males and 14 times among females when compared to the general population (26,27). Substance use disorders were most likely to be the most severe form of the illness, with Alcohol (50%) and Cannabis (20%) the most likely substances (26). Mental illness affects all age groups of Aboriginal people in contact with the justice system, including young people. More than 80% of young Aboriginal people in a Queensland youth detention centre scored above the cut off for a mental health problem (28).

High rates of illness have post-release implications, with higher rates of recidivism and criminal activity associated with prisoners that have any type of health condition (physical, mental or substance abuse) (29). Prisoners are also more likely to be hospitalised after they are released from prison, with more than one in five Aboriginal prisoners in Western Australia hospitalised at least once within 12 months of their release (24). Almost a third of female Aboriginal prisoners were hospitalised in that time, with mental and behavioural disorders the second most common reason for hospitalisation (24).

5 Study overview

5.1 Aim and objectives

The study aimed to explore ways to improve continuity of care for Aboriginal people in Victorian prisons and identify ways to improve relationships and partnerships between ACCHOs and prison health services.

5.2 Methodology

A background literature review was completed to inform interview questions. These questions were used in phone and face-to-face interviews with seven practice managers at ACCHOs and seven health service managers at prison health services. In addition a focus group was conducted at a gathering of Aboriginal Wellbeing Officers and Aboriginal Liaison Officers working in the Victorian prison system for Corrections Victoria. Interviews were recorded where appropriate and possible and interviewees were provided with a copy of interview notes with full editing rights after the interview occurred. The research questions as articulated in the original plan are outlined in Table 1.

Table 1: Study questions

Client history and continuity into prison	<p>1. <i>How do prison health services maintain continuity of care for Koori clients?</i></p> <ul style="list-style-type: none"> • How do they ensure they have a comprehensive and accurate health history for the client? • How do prison health services access a client's health history?
Health monitoring and recall	<p>1.1 <i>How do they maintain regular follow-up to monitor and treat existing illnesses and chronic diseases?</i></p> <ul style="list-style-type: none"> • How do Koori clients come into contact with the prison health service? • How can obstacles to continuity of care be overcome? • Are there any procedural obstacles to innovative approaches to maintaining continuity of care for Koori clients such as utilising ACCHO and AHWs?
Continuity of care around transition	<p>1.2 <i>How do prison health services maintain continuity of care for clients post-release?</i></p> <ul style="list-style-type: none"> • How do they ensure comprehensive hand-over when Koori prisoners are released?
Establishing and maintaining links between ACCHOs and prison health	<p>2. <i>How do prison health services establish and maintain links with GPs within ACCHOs who have clients within prisons?</i></p> <ul style="list-style-type: none"> • What do prison health services know about ACCHOs? • How do prison health services perceive greater links with GPs and AHWs within ACCHOs might enhance prison health services and Koori prisoner patient care?
ACCHO role in prisoner health care	<p>3. <i>How do ACCHOs ensure clients in prison receive comprehensive health services?</i></p> <ul style="list-style-type: none"> • How do ACCHOs ensure continuity of care for Aboriginal clients entering the prison system? • How do ACCHOs involve their allied health programs and AHWs in Koori client/prisoner care? • How do ACCHOs ensure continuity of care for clients released from the prison system? • How do ACCHOs perceive links between prison health services and AHWs within ACCHOs could enhance the care of their Koori clients?

The focus on continuity of care did not preclude exploration of other themes identified by people interviewed.

6 Results and discussion

6.1 Part One: Continuity of care for Aboriginal prisoners

6.1.1 Pre-prison health history and continuity

6.1.1.1 Reception processes for Aboriginal prisoners

Given the high rates of health and mental health problems among Aboriginal prisoners (3,4,10,26), the prisoner reception process is an ideal time to begin diagnosis and treatment as many are likely to require follow up. Koori peoples' reluctance to use mainstream health services (30) makes the first contact with prison health services critical to encourage future engagement. Presently, many prisoners are not afforded adequate time on prison reception. Reception time constraints that force doctors to assess prisoners quickly – sometimes in five to 10 minutes (31) – are unlikely to foster an environment where prison health practitioners can build trusting relationships, address prisoner concerns and anxiety and conduct comprehensive primary care assessments. Due to the greater likelihood of Aboriginal prisoners consulting with a medical professional in prison rather than in the community, (4,11), there is a need for prisoner reception processes that encourage access and utilisation of prison health services. If adequate time is not available to develop trust and offer holistic care in the initial consultation, Aboriginal prisoners are likely to be discouraged from accessing the prison health service (30,32). Considering the prison health service is the only health care option available to prisoners, poor or inadequate reception can exacerbate unmet health needs.

Accounts of Aboriginal and non-Aboriginal prisoner reception processes were similar – for example, all new arrivals were received into the prison's health service within 24 hours. Evidence from interviews suggested that several Aboriginal-specific requirements were not being met during reception, particularly related to the absence of cultural safety training among staff members. Justice Health's Policy and Quality Framework requires the following of prison health services:

(Key Requirement 3.1.3)

Aboriginal and Torres Strait Islander issues are considered and incorporated into planning processes for the training of staff and the delivery of health services to Aboriginal and Torres Strait Islander Patients/Clients.

(Standard 2.1)

Health Services are responsive to Patients/Clients who are Aboriginal and Torres Strait Islander, culturally and linguistically diverse, and those with specific needs.

(Key Requirement 2.1.8)

Aboriginal and Torres Strait Islander Patients/Clients' physical, social, spiritual and emotional wellbeing is addressed in a manner that is consistent with their cultural needs. (33)

One prison health service identified the first month at each prison as a particularly difficult period for Aboriginal prisoners. Aboriginal Liaison Officers (ALOs) and/or Aboriginal Wellbeing Officer (AWBOs) advocated for greater Aboriginal representation at each prison reception. Only a small number of prisons incorporated an ALOs or AWBOs into prisoner health reception. ALOs and AWBOs felt an Aboriginal worker at reception mitigated feelings of anxiety experienced by many Koori prisoners.

6.1.1.2 Pre-prison health history

Evidence from ACCHOs interviewed suggested they are rarely contacted by prison health services to access Aboriginal prisoners' pre-prison health histories with no ACCHO able to recall a prison health service requesting such details. However, at reception into the prison system the mental health provider – Forensicare – accesses the RAPID data based; providing information on any contact with public mental health services. This information is noted in the prisoner health record. Health histories were often

self-reported, except in cases of significant illness where deemed appropriate by the health practitioner. Prisoners transferred from other prisons usually arrived with a discharge summary prepared by the previous prison health service. Prison health workers believed self-reported data was generally accurate, although feedback from interviews suggested that continuity of medication and general health care relied on the ability of prison health services to independently clinically diagnose and identify existing health problems or relied on the accuracy of the prisoner's memory.

While Aboriginal prisoners were more likely to access health services in prison than in the community, there were still many that had consulted with a medical professional prior to imprisonment. By relying on self-reporting the prison health system was potentially unaware of important information. ACCHOs, ALOs and AWBOs were concerned that Aboriginal people were asked to retell their stories frequently throughout the justice system as well as other service providers, which resulted in people feeling it was futile to divulge their background as it led nowhere. Further, retelling traumatic experiences such as those related to the Stolen Generations and abuse with people they lacked trust and rapport is unlikely to be an environment that encourages full or even partial disclosure of important information. Without a culturally safe environment to disclose sensitive and traumatic personal details, Aboriginal prisoners may be frustrated and deterred from accessing the prison health service. Another concern raised by ACCHOs was related to the fallibility of self-reported health history. In a study among traumatic brain injury patients, self-reports were generally accurate when measured against actual records, however 'excessive drinkers' were less likely to accurately recall details (34). Given high rates of substance use disorders among Aboriginal prisoners, particularly alcohol (11,26), it is possible that self-report reliability may be affected (11). Conscious and unconscious practitioner prejudices toward gender (e.g. females not as aggressive as males), race (e.g. Black Americans more likely to be perceived as violent than White Americans), and more can also affect mental health diagnosis (35). Obtaining non-prison health and mental health histories ensures greater accuracy, reduces story repetition and establishes links with the prisoner's community health practitioners which will improve post-release continuity.

Some prisoners attend their local ACCHO to prepare for a custodial sentence. For example, one ACCHO practice manager described a number of prisoners requesting to be transitioned from methadone to Suboxone before a prison sentence. Others prepared prescription medication for health conditions including diabetes when they thought they were going to be imprisoned. It is not clear whether this information, which forms a part of the person's health and mental health history, is discussed between the prisoner and prison health practitioner. Communicating health information between Aboriginal health services and mainstream providers is not a new idea. The RCIADIC raised patient health information transfer as shown below.

(RCIADIC – Recommendation 250)

That effective mechanisms be established for communicating vital information about patients, between the mainstream and Aboriginal community-based health care services. This must be done in an ethical manner, preserving the confidentiality of personal information and with the informed consent of the patients involved. Such communication should be a two-way process.

(RCIADIC – Recommendation 157)

That, as part of the assessment procedure outlined in Recommendation 156, efforts must be made by the Prison Medical Service to obtain a comprehensive medical history for the prisoner including medical records from a previous occasion of imprisonment, and where necessary, prior treatment records from hospitals and health services. In order to facilitate this process, procedures should be established to ensure that a prisoner's medical history files accompany the prisoner on transfer to other institutions and upon re-admission and that negotiations are undertaken between prison medical, hospital and health services to establish guidelines for the transfer of such information. (6)

Sharing personal health information between prison health services and community-based health providers has found wide support among people in British prisons. When prisoners were asked about

health care appointments and sharing information between services over 80% were happy for their medical information to be exchanged, with a strong preference for one person to have an overview of all their health needs (36). Some ACCHOs identified a lack of medication continuity between community and prison as a common complaint. Knowing the prisoner's health history also has a secondary effect of building trust and rapport.

Paper-based health record systems at all prisons (except Fulham) prohibited good practice in continuity of care that personalised electronic health records offer. Prison health services echoed the Victorian Ombudsman's report into the health of Victorian prisoners that emphasised the need and usefulness of an electronic health records system in the Victorian prison system (31). Establishing an electronic health records system in Victoria's prison health system was also identified as a 'key current priority' by the Australian Institute of Health and Welfare (AIHW) in 2009 and 2010 (4,37).

Electronic health records would also provide greater Aboriginal prisoner health statistics. Presently, very limited health data exists for Aboriginal people in the justice system (12), and this study found no exception in the prison health system. Data availability is critical for ACCHOs and other health services to respond to and plan for the greater health needs of Aboriginal prisoners and to meet state and national goals in initiatives such as Closing the Gap.

6.1.2 Health monitoring and patient recall

6.1.2.1 Patient recall

Key Requirement 2.2.4 of the Justice Health Policy and Quality Framework Standard 3.7 requires that all Aboriginal prisoners have a chronic disease management plan (33). This practice is generally followed, although one prison health service was averse to placing all Aboriginal prisoners on a chronic disease management plan based solely on their Aboriginality, especially when a number of (usually) younger prisoners were physically healthy.

A prisoner's E*Justice³ record is coded as M2 ("medical condition requiring regular or ongoing treatment") when they are placed on a chronic health care plan. This is the E*Justice system's second highest risk level for medical conditions (38). Prison health services indicated that they follow up prisoners with a chronic disease management plan at least every 12 months in line with Justice Health's policy framework (33), although most indicated they initiate recall more often, especially for specific health conditions such as asthma. While there are very high levels of health problems among Aboriginal prisoners, it is unlikely that all have a medical condition that requires regular or ongoing treatment. Given the very high rates of holistic health problems, including mental health (26), expanding the definition of medical condition to include greater attention among prison health staff on assessing mental health and social and emotional wellbeing could encourage more focus on health conditions most prevalent among Aboriginal prisoners.

One prison health service expressed a desire to understand how Aboriginal prisoners feel about their health care service. Presently no feedback is obtained from prisoners and the health service was unsure if this was due to health service satisfaction or a lack of access to evaluate their experience. High rates of prison health complaints to the Health Services Commission and the Victorian Ombudsman have been reported in recent years (39,40) indicating low levels of satisfaction. All recommendations made by the Ombudsman have been acquitted, and some recommendations have been implemented, however there is no available data on prison health service satisfaction among Aboriginal prisoners. Ongoing feedback and periodic health service satisfaction surveys could be considered, including measuring and reporting on performance against Section 3.2.3 (Aboriginal and Torres Strait Islander health) of the Justice Health Policy and Quality Framework. ALOs/AWBOs could assist with prisoner health feedback as most were aware of Aboriginal prisoner health complaints and may offer a better insight into why people are not accessing health care.

³ E*Justice is the electronic Sentence Management System (it is not health-specific). Other risk codes include: Suicide/self harm (S1-S4), Violence (V1-V3), Placement (T1-T3), Security (E1-E4), and Psychiatric (P1-P4). Medical conditions are rated from M1-M3 in order of descending risk levels.

6.1.2.2 The role of Aboriginal Liaison Officers and Aboriginal Wellbeing Officers

Aboriginal Liaison Officers and Aboriginal Wellbeing Officers are present in many but not all Victorian prisons and most have an informal relationship with prison health services. The diverse ALO/AWBO role supports, assists and advises Aboriginal people in prison as well as prison staff members (see Appendix 2 for a position description) (41). Prison health services supported the presence of ALO/AWBOs, and several were confident that their involvement increased Aboriginal prisoners' health care access and engagement.

Not all ALO/AWBO positions are filled by Aboriginal people and some interviewees felt that a number of Aboriginal prisoners were discouraged from accessing the support offered by non-Aboriginal people employed in this role. With many prison health services deferring to ALOs/AWBOs to engage and support Aboriginal prisoners' health needs, a lack of engagement between Aboriginal prisoners and the ALO/AWBO may also restrict access to prison health services. The lack of cultural safety within prison health appears to be a significant factor driving prison health staff members' contact with ALOs/AWBOs. The need to address cultural safety in prison health services is discussed in 6.1.2.3.

The assistance of the ALO/AWBO was widely viewed as positive, however there are limitations to the ALO/AWBOs' role that must be acknowledged and respected, as outlined in Table 2 below.

Table 2: Limits to Aboriginal Liaison/Wellbeing Officers' role in prison health care

Barrier	Discussion
Patient confidentiality	Prison health services can only disclose general information (unless written consent is provided), limiting the ability of the ALO/AWBO to comprehend the problem the prison health service needs assistance with.
Position competencies	The ALO/AWBO's responsibilities and key selection criteria do not include health (41). Whilst the ALO/AWBO is a useful resource for the prison health service, they should not be expected to fulfil the role of an Aboriginal Health Worker without appropriate health qualifications and experience, which few ALOs/AWBOs, if any, are recruited with. A study in UK prisons found that prisoners that sought assistance for mental health problems were least likely to be influenced by non-medical prison staff members, suggesting poor mental health identification skills (36). ALO/AWBOs are not recruited for their ability to identify health and mental health problems and should not be relied upon to perform this task.
Capacity constraints	ALOs/AWBOs are responsible for supporting anywhere from 20 to 80 Aboriginal prisoners daily. Their already high caseloads require involvement with a variety of prison staff members in many capacities that include case management, event management (e.g. NAIDOC week, barbecues with elders, etc.), building and maintaining relationships with Aboriginal organisations, transition planning, and many other undocumented roles, including liaison with prison health workers. With the Aboriginal prison population expected to grow, higher caseloads will increasingly limit the ALO/AWBOs' role in health care.

It was evident that prison health staff members value and often defer to the ALO's advice and assistance. This cooperation reflects the expertise and capabilities that ALOs bring to the Victorian justice system and the widespread reliance that prison health services have on the people performing these roles. However the role's limitations (described in Table 2, above) in relation to prison health care should be acknowledged by prison health services. As it operates, the informal arrangement between prison health services and the ALO/AWBO does not meet Justice Health's Aboriginal and Torres Strait Islander health Policy and Quality Standards. Support and advice from ALOs should complement a culturally safe prison health service, not be relied upon to meet the prison health service's obligations to develop a culturally safe health service. Cultural safety in prison health services (and methods to develop cultural safety) is expanded upon in 6.1.2.3.

6.1.2.3 Cultural awareness and cultural safety

A lack of cultural awareness was acknowledged by most prison health services, and several expressed a desire for access to Aboriginal health statistics, trends, general health-related information, as well as culturally appropriate methods of care. Some prison health services acknowledged that the lack of cultural understanding engendered a lack of trust and encumbered communication and understanding between Aboriginal prisoners and prison health workers. Culturally specific health materials were limited to some Koori health information brochures on topics such as blood borne viruses, alcohol and other drugs, and sexual health.

A lack of confidence afflicts practitioner and prisoner alike. Recounting consultations with Aboriginal prisoners, some prison health services were unsure how to confidently interact with Aboriginal prisoners – for example, if they should mirror colloquial language use of 'brother' and 'cousin'. There was an impression that prison health services are outsourcing their responsibility to be culturally aware and competent to ALO/AWBOs. This does not seem to be an intentional abdication of responsibility, more a lack of confidence due to a lack of training and experience working with Aboriginal people and communities. The consequences of poor cultural understanding, respect and community connection have deterred Koori people from accessing mainstream health services because they "did not feel understood as individuals or as a culture" (30), and it is likely this also applies to the prison health system.

A lack of cultural safety in the justice system has been discussed at least since the RCIADIC identified similar themes in 1991. The RCIADIC recommended training to increase Aboriginal cultural understanding and develop cultural safety, specifically targeting prison health employees.

(Recommendation 154)

That:

- a. All staff of Prison Medical Services should receive training to ensure that they have an understanding and appreciation of those issues which relate to Aboriginal health, including Aboriginal history, culture and life-style so as to assist them in their dealings with Aboriginal people;*
- b. Prison Medical Services consult with Aboriginal Health Services as to the information and training which would be appropriate for staff of Prison Medical Services in their dealings with Aboriginal people; and*
- c. Those agencies responsible for the delivery of health services in correctional institutions should endeavour to employ Aboriginal persons in those services.*

(Recommendation 247)

That more and/or better quality training be provided in a range of areas taking note of the following:

- a. Many non-Aboriginal health professionals at all levels are poorly informed*

about Aboriginal people, their cultural differences, their specific socio-economic circumstances and their history within Australian society. The managers of health care services should be aware of this and institute specific training programs to remedy this deficiency, including by pre-service and in-service training of doctors, nurses and other health professionals, especially in areas where Aboriginal people are concentrated;

- c. *Health care staff working in areas where Aboriginal people are concentrated should receive specific orientation training covering both the socio-cultural aspects of the Aboriginal communities they are likely to be serving and the types of medical and health conditions likely to be encountered in a particular locality. Such orientation programs must be complemented by appropriate on-the-job training (6)*

The RCIADIC identified some of the areas that the Department of Justice, through Justice Health, could help to ensure culturally appropriate care is provided to Aboriginal prisoners.

(RCIADIC – Recommendation 152)

That Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon, the following matters together with other matters thought appropriate:

- a. *The standard of general and mental health care available to Aboriginal prisoners in each correctional institution;*
- b. *The extent to which services provided are culturally appropriate for and are used by Aboriginal inmates. Particular attention should be given to drug and alcohol treatment, rehabilitative and preventative education and counselling programs for Aboriginal prisoners. Such programs should be provided, where possible, by Aboriginal people;*
- c. *The involvement of Aboriginal Health Services in the provision of general and mental health care to Aboriginal prisoners;*
- e. *The exchange of relevant information between prison medical staff and external health and medical agencies, including Aboriginal Health Services, as to risk factors in the detention of any Aboriginal inmate, and as to the protection of the rights of privacy and confidentiality of such inmates so far as is consistent with their proper care*

Some prison health services identified the need for fundamental changes in prison health staff members' understanding of Aboriginal health, including the nuances of Aboriginal prisoner health. At the time of this study, no prison health service had provided cultural awareness training to its workers. Many interviewees had heard of plans to provide training in the near future, however it was unclear what it would look like, what the level of engagement with Aboriginal people and organisations would be and how often it would be delivered. Recognising that changes are needed within the prison health service is a sentiment that prison health management can build upon by training staff members and reflecting on how prison health systems engage with and support the health needs of Aboriginal prisoners. While cultural awareness and cultural safety has not progressed from policy to standard practice, Justice Health's Policy and Quality Framework lists some of the requirements to improve prison health engagement with Aboriginal prisoner health needs.

(Key Requirement 2.1.11)

Health Services promote the employment of culturally appropriate healthcare staff and the choice of an Aboriginal and Torres Strait Islander Health Worker, where available.

(Key Requirement 2.3.1)

Health staff are provided with Aboriginal and Torres Strait Islander cultural awareness education and training to assist them to deliver healthcare to Aboriginal and Torres Strait Islander Patients/Clients, in accordance with Director's Instruction 2.7 Aboriginal and Torres Strait Islander Prisoners.

Standard 5.1: Clinical governance and leadership

(Key Requirement 3.1.2)

Aboriginal and Torres Strait Islander cultural competencies must be developed and implemented with appropriate consultation.

(Key Requirement 3.1.3)

Aboriginal and Torres Strait Islander issues are considered and incorporated into planning processes for the training of staff and the delivery of health services to Aboriginal and Torres Strait Islander Patients/Clients. (33)

Port Phillip Prison is the only prison that meets some of the above standards, with an Aboriginal Hospital Liaison Officer attending one day a fortnight as part of her role at St Vincent's Hospital. One prison health service recalled an Aboriginal worker being employed across Marngoneet and Barwon prisons approximately three or four years prior to being interviewed for this study when still operated by St Vincent's Correctional Health. Following the worker's resignation six weeks later however, a replacement was never employed. It is unknown what mediums the position was re-advertised through. One prison health service acknowledged that working in the prison health environment is different to community health and does not suit all people. While there remain challenges in attracting Aboriginal people into prison health, providing incentives such as traineeships and building relationships with universities and other trainers of Aboriginal health and medical professionals could help boost numbers.

Determining the level of motivation to improve cultural safety in prison health services is difficult because a range of views are held. Two prisons that had a similar population of approximately 20 Aboriginal prisoners illustrate the difference in views. One prison health service (PHS1) that supported introducing prison-based AHWs saw no need for AHWs in that particular prison because there were not enough Aboriginal people. The other service (PHS2) felt AHWs were pivotal to improving Koori prisoner health, especially mental health. PHS2 believed health and mental health would only improve after a fundamental change in prison health workers' attitudes toward and understanding of Aboriginal people. Another prison health service emphasised that they do nothing different for Aboriginal people or for any other person in the prison system, in contradiction of Justice Health Policy and Quality Standard 2.1 and most of its 15 Key Requirements that require health services to respond to the needs of Aboriginal and non-Aboriginal prisoners.

(Standard 2.1)

Health Services are responsive to Patients/Clients who are Aboriginal and Torres Strait Islander, culturally and linguistically diverse, and those with specific needs.

(Key Requirement 2.1.8)

Aboriginal and Torres Strait Islander Patients/Clients' physical, social, spiritual and emotional wellbeing is addressed in a manner that is consistent with their cultural needs. (33)

To improve cultural competency and safety in line with Justice Health's Policy and Quality Framework and recommendations of the RCIADIC, prison health services will need to systemically address processes, practices and behaviour. Courses such as VACCHO's *Introduction to Cultural Safety* for Executive and Management employees and frontline service providers are an important part of increasing services' understanding of how to address the holistic health needs of Aboriginal prisoners. Contrasting views and a lack of understanding illustrate a need to systematically embed cultural

safety. Increasing internal and external monitoring and accountability by reporting on and measuring performance against agreed upon targets will help all prison health services work towards common prison, State, and Federal Aboriginal health goals. Embedding cultural safety will require senior management commitment at each prison health service with guidance and accountability offered by Justice Health. There are a number of tools that could assist prison health services to improve their cultural safety such as Reconciliation Action Plans (RAPs), which can be found on the Reconciliation Action Plan online hub⁴. The Making Two Worlds Work⁵ website, developed by Mungabareena Aboriginal Corporation and Women's Health Goulburn North East, also offers cultural safety audit guides as well as posters, health promotion and evaluation tools. A next step could be to adapt, for prison health services, the *Aboriginal and Torres Strait Islander Patient Quality Improvement Toolkit for Hospital Staff*, developed by the Cooperative Research Centre for Aboriginal Health (now the Lowitja Institute), the Aboriginal Health Council of South Australia, La Trobe University and Onemda VicHealth Koori Health Unit.

ALOs and AWBOs widely believed that prison health services needed to increase their engagement with the Aboriginal community and awareness of ACCHOs. People interviewed felt that establishing regular contact with the local ACCHO would be one way of increasing specific and general awareness of Aboriginal health and culture. This relationship could also benefit by sharing resources such as Koori-specific tools such as personal chronic disease management booklets at the Victorian Aboriginal Health Service (VAHS) requested by one prison health service manager, although she was unaware if such a resource would be directly applicable. Other suggestions for improving relationships included attending Regional Aboriginal Justice Advisory Committee (RAJAC) and/or Local Aboriginal Justice Advisory Committee (LAJAC) meetings (often attended by staff members of local ACCHOs), as well as attending meetings of ALOs and AWBOs.

Building relationships and partnerships between prison health services and Aboriginal community organisations are important to improving Aboriginal prisoner health. One interviewee suggested prison health services could offer practical placements for AHWs during Certificate III training. This could also extend to other health professions such as nursing. Placement opportunities form a part of Reconciliation Action Plans and help to develop the prison health service's cultural safety. Regular and ongoing placement and traineeship opportunities help to break down any barriers to employment of Aboriginal people in prison health care and help prison health services to develop relationships and partnerships with Aboriginal health organisations. Considering one prison health service gave an example of difficulties in attracting Aboriginal people to prison health roles, placement and training opportunities are a practical way to attract more Aboriginal people to the prison health system.

ALOs and AWBOs also called for greater Koori representation in prison health policy. Justice Health is responsible for setting policy and standards and managing prison health provider contracts. Planning of prison health services is overseen by Department of Health, Justice Health, Corrections Victoria and Victoria Police representatives on the Joint Management Committee (JMC). A clinical advisory committee advises Justice Health and the JMC on best practice, policy, patient safety, and quality and clinical leadership. Participants felt that the committees should include community representation given high Koori imprisonment rates, health and mental health problems. This action would also improve accountability to the Koori community as espoused within Justice Health's Policy and Quality Framework. Beyond Aboriginal recruitment strategies, participants thought that prison health service tenders should be offered to Koori organisations, and that Aboriginal health services could deliver services and advocate on behalf of Aboriginal prisoners.

4 <http://raphub.reconciliation.org.au/>

5 <http://www.whealth.com.au/mtww/>

6.1.2.4 Secondary and tertiary health care

All prisoners must transfer to Port Phillip Prison to receive secondary and tertiary health care, except in emergencies. Corrections Victoria does not hold cells for prisoners requiring transfer for health care needs⁶ and prison health services must also operate within this system⁷ (31).

Prison health services, ACCHOs, ALOs and AWBOs agreed that many Aboriginal prisoners have refused health care appointments and operations because they did not want to transfer to Port Phillip Prison, a problem that appears to affect the broader prison system. It isn't known if Aboriginal prisoners experience different rates of refusal. Many people interviewed spoke of the anxiety and fear associated with transferring to Port Phillip Prison, often because they were likely to lose their prison cell, privileges and training program places. They were also reluctant to relinquish the greater liberties awarded in medium and minimum security prisons for the restrictions and dangers in a large, maximum security prison. The Ombudsman interviewed one prison doctor in 2011 that claimed that "[prisoners] would literally rather die than go to Port Phillip [Prison] so they are refusing medical treatment" (31).

Refusing treatment and transfer to Port Phillip Prison is likely to compound already high levels of morbidity and mortality that exist among Aboriginal prisoners. While Aboriginal people are slightly more likely to access health care in prison (although less likely to see an Aboriginal health worker) (10), exiting the prison system with unmet health needs is likely to lead to people returning to an environment where we know it is less likely they will seek health care (i.e. in the community compared to prison) (4,11). The prison system therefore becomes an increasingly important health intervention point and opportunity to improve health and wellbeing. In addition to encumbering access to health care treatment, we know that higher rates of recidivism and criminal activity are also associated with prisoners that have any type of health condition – physical, mental or substance abuse (29).

Many of the ALOs and AWBOs, prison health workers and ACCHOs supported actions such as those recommended by the Victorian Ombudsman to overcome the secondary and tertiary health care barriers. The Ombudsman has reported these findings to State parliament and the Department of Justice (31,42). This topic was raised with Justice Health who informed us that they are investigating the use of Telehealth as an alternative to transferring prisoners to Port Phillip Prison.

Whilst far from a panacea, a partnership focused on strong transition and release processes between prison health services, ACCHOs and Justice Health could help mitigate some of the consequences of unmet health needs among Aboriginal prisoners while longer term solutions are implemented. Prison health services and ACCHOs might also discuss how to improve transition support with prisoner transition support agencies, especially for people with unmet health needs. Transition support models are discussed in 6.2.2.

6.1.2.5 Mental health and social and emotional wellbeing

Prison health services and ACCHOs identified a need to develop specific Aboriginal mental health competencies among prison health workers and agreed that the mental health of Aboriginal people must be improved in and out of prison. There is mounting evidence that Aboriginal people in prison experience higher rates of mental health problems than the non-Aboriginal prison population (26). Despite these findings, mental health diagnosis and treatment is lower among Aboriginal prisoners when compared to the general prison population (4). The discrepancy suggests many Aboriginal people are not diagnosed and treated prior to entering prison and therefore prison presents an opportunity to improve mental health. Given that mental health problems are commonly worse among people on

6 "it is not possible, at present, for prisoners attending medical appointments to retain their cells/beds/work-related privileges. To ensure numbers of prisoners in police cells are kept to a minimum, it is not viable to have vacant cells at country prisons, waiting to return from medical appointments. As it is not always known how long prisoners will be away, their critical work position must be filled, at least temporarily. In the meantime, prisons try to enable returning prisoners to 'fast-track' their way back to original cells or work positions." (31)

7 "Any effective decrease in the number of available beds in the prison system (which is a consequence of 'holding beds') will have a flow on impact. This may, for example, result in more prisoners being detained in police cells for longer periods." (31)

remand (26,43) and Aboriginal people are more likely to be on remand (13), improving mental health diagnosis and treatment processes should begin prior to sentencing.

Mental illness among Aboriginal prisoners has post-release implications, including higher rates of death (22). In a Western Australian study Aboriginal people released from prison were found to be more likely than non-Aboriginal people to experience hospitalisation after their release with mental health and behavioural disorders the second most common reason for hospitalisation and the highest number of 'bed days' (24). Almost a third of Aboriginal women were hospitalised within 12 months (24).

One prison health service felt there were an increasing number of young Aboriginal people with mental health problems entering prison. Similar trends have been identified in other Australian states – for example, 81% of young Aboriginal people in a Queensland youth detention centre scored above the cut off for a mental health problem (28).

Many Aboriginal people are reluctant to discuss their mental health, with one prison health service identifying a lack of prisoner-practitioner trust and understanding as a barrier. Several ACCHOs were of the view that mental health of Aboriginal prisoners worsens during custodial sentence and that people involved in psychiatric assessment and treatment did not have a history of working with Aboriginal people nor possessed culturally appropriate skills to improve Aboriginal prisoners' mental health and wellbeing. Together with a lack of holistic programs addressing social and emotional wellbeing, some ACCHOs, ALOs and AWBOs suggested poor mental health practices resulted in some Koori prisoners exiting prison without beginning to have their mental health problems addressed. The qualifications and experience of mental health workers in the prison system was not explored, however the necessity of recruiting people that have appropriate experience with the Aboriginal community is an important one raised by the RCIADIC, recommendation 151:

...wherever possible, Aboriginal prisoners or detainees requiring psychiatric assessment or treatment should be referred to a psychiatrist with knowledge and experience of Aboriginal persons. The Commission recognises that there are limited numbers of psychiatrists with such experience. The Commission notes that, in many instances, medical practitioners who are or have been employed by Aboriginal Health Services are not specialists in psychiatry, but have experience and knowledge which would benefit inmates requiring psychiatric assessment or care. (6)

Prison health services and ACCHOs pointed out the need for Aboriginal people to be recruited in prison mental health positions – which was a recommendation of the RCIADIC (Rec. 265) (6). One prison health service advocated for an increase in per capita Aboriginal mental health spending to meet needs. The value of Aboriginal mental health workers has been described as “indispensable” by psychiatrists during a recent Western Australian initiative (44), which augurs well for a future role in the Victorian prison health system. Recruiting Aboriginal workers into prison mental health roles could propel mental health diagnosis and treatment among a cohort of people with great unmet needs. Many people interviewed felt employing and training Aboriginal Health Workers in the prison health system would engage more Aboriginal prisoners and thus help to meet the holistic health care needs pivotal to improving Aboriginal health outcomes.

VACCHO and Justice Health were steering committee members of Monash University's Koori Prisoner Mental Health & Cognitive Functioning Study. The study aimed to 'provide an evidence-based guide to the development and enhancement of culturally appropriate health care and support of prisoners in correctional facilities and will promote optimal mental health and well-being of Koori prisoners'. More than 100 Aboriginal prisoners were interviewed, and the final report outlined changes to mental health policy in the prison system. That study provides more advice and guidance on improving Koori mental health in the prison system.

6.1.2.6 Alcohol and other drugs

Alcohol and other drugs are intertwined with mental health and social and emotional wellbeing. Prisoners often misuse substances in response to mental health problems, and substance use also engenders and exacerbates mental health problems. Aboriginal prisoners experience greater substance use problems than the general prison population, which itself is already much higher than the general population (3,4,11). This view was supported by prison health, particularly alcohol, raised as a problem by several.

Substance use withdrawal, particularly from alcohol, was identified as a not uncommon experience among Koori prisoners by one prison health service. Investigations around the country have found very high rates of substance misuse among Aboriginal prisoners. Aboriginal prisoners in New South Wales were more likely to be intoxicated at the time of offence (73% compared to 59%) (11), and almost three quarters of Aboriginal prisoners nationally have been found at high risk of alcohol-related harm in the 12 months prior to prison – much higher than the general prison population (4). Substance use disorders were identified in more than two-thirds of Aboriginal people in Queensland prisons, a rate 13 times greater among males and 14 times among females compared to the general population (26,27). Substance use disorders were usually the most severe form of the illness, with alcohol (50%) and cannabis (20%) the most likely substances misused (26).

Some ACCHOs identified injecting drug use as a significant problem within prison walls among Aboriginal prisoners. Little information exists in Victoria, but in New South Wales 19% of male and 16% of female Aboriginal prisoners had injected drugs in prison (11). Injecting drug use should be addressed in prison as highlighted within Justice Health's Policy and Quality Framework. This was initially recommended by The National Aboriginal and Torres Strait Islander Drug and Alcohol Committee of the Australian National Council on Drugs. The report recommends "ensuring access to a full range of effective drug and alcohol treatments, as well as mental health services, which are well suited to treating Indigenous offenders (and their families), as are available to the wider community" (45). This will require more attention and improved Koori-specific diagnosis on reception given the low rates of mental illness diagnosis among the Aboriginal prisoner population (4). Comprehensive, culturally appropriate health and wellbeing screening at reception would improve diagnosis and begin addressing Koori prisoner mental health needs often masked by substance misuse. Developing partnerships with ACCHOs and community-based substance abuse programs using best practice models need to be further developed to ensure Aboriginal prisoners can access appropriate care after their release. All discharge plans should be followed up after the prisoner's release and include all contacts and appointments for Aboriginal prisoners, especially those with substance abuse problems given the extremely high rates. Active weekly follow up has been shown to increase contact with general practitioners and mental health services and is discussed further in 6.2.2.1.

Prison health services and ACCHOs identified the difficulty to locate opioid substitution therapy dispensing pharmacies outside Melbourne; this is discussed further in 6.1.3.4. In New South Wales over 50% of Aboriginal women in prison have been enrolled in a methadone program (compared to 38% of non-Aboriginal women), while the number of Aboriginal men increased from 12% in 1996 to 26% in 2009 – a rate now higher than non-Aboriginal men (19%) (11). Accurate illicit drug use statistics among Victorian Aboriginal prisoners are not widely available, and large jurisdictional differences make it difficult to infer rates. No difference in Aboriginal and non-Aboriginal illicit drug use has been identified in some studies (4), however others have found higher rates of 'daily or almost daily' use of any illicit drug in the year before prison among Aboriginal people (51% compared to 38%) (11). Access to Victorian statistics is needed to assist policy decisions in this area, however if following a similar trend to New South Wales, an increasing number of Aboriginal people will access methadone or other opioid substitute programs.

6.1.3 Continuity of care around transition

6.1.3.1 Release planning

Prison health services began preparing prisoner health histories and identifying appropriate post-release health services three to six weeks prior to release. One service delayed release planning until the final week of a prisoner's sentence based on their experience that prisoners' post-release plans frequently change in their final month. Each prisoner is provided with a list of post-release appointments, between three and seven days of medication, and a copy of their discharge summary. Once people are released they are no longer the responsibility of the prison health service, highlighting a gap in the transition process identified by Kinner et al, who call for a routine monitoring system for ex-prisoners and to continue the duty of care beyond prison walls (23).

Finding a balance between prisoner responsibility and duty of care relies on active, engaged partnerships with ACCHOs to ensure health care needs receive attention outside prison. Describing what is meant by 'specific needs' and 'comprehensive transition support' in Standard 1.4 of the Policy and Quality Framework through consultation with ACCHOs is required to guide this balance:

Comprehensive discharge planning (italics added) is in place for Patients/Clients requiring ongoing healthcare, *Aboriginal and Torres Strait Islander Patients/Clients* (italics added) and Patients/Clients with specific needs, before discharge from a custodial inpatient facility or in preparation for their release from custodial settings back to the community.

The Service Provider ensures that Aboriginal and Torres Strait Islanders and Patients/Clients with specific needs receive comprehensive transition support appropriate to their cultural, health and specific needs. (33)

Parole and court release planning was rated as very poor by many ACCHOs, ALOs and AWBOs in this study. Prison health services also recognised that this form of release created problems. Some ACCHO workers spend entire days collecting prisoner possessions (from prison, including medications), organising support services, and organising medical appointments (especially for medications) because plans were not in place for prisoners. The intensive support requires ACCHO workers to focus attention on one person at the expense of others. ACCHO workers are placed in a difficult position where despite the support required being outside their responsibilities they are the only person that can assist the former prisoner at that point in time and feel obliged to go beyond their scope of practice (one worker even housed a former prisoner because there were no other housing options). ACCHOs expressed frustration at the number of times prisoners had no plans for release at parole hearings and court release and the poor quality of medication, health and mental health information communicated in such circumstances. Most suggested that release planning should be initiated for all prisoners with a parole hearing or court appearance.

ACCHOs are seldom contacted prior to a prisoner's release, even in typical prisoner release situations (i.e. not parole or court release). None recalled a prison health service contacting them to arrange a post-release appointment or to share Aboriginal prisoner health information. This appears to fail any interpretation of comprehensive transition support discussed above. ACCHOs almost unanimously identified the lack of release planning as a fundamental barrier affecting their ability to assist recently released prisoners. Appointments made outside the ACCHO sector were not discussed. ACCHOs became aware of people being released from prison through the Koori grapevine or the prison's ALO and occasionally the ACCHO's local justice worker is involved in picking the former prisoner up upon release. In most cases ACCHOs found former prisoners were more likely to re-engage using the ACCHO's non-health services – commonly housing and other social support – although most were unlikely to attend the service without a pressing need. General, non-medical, prisoner release planning begins months before the end of a sentence, which makes it possible to begin planning sooner and allow enough time for ACCHOs to coordinate post-release services.

The transition between prison and community is dangerous. The first four weeks and the first year after a prisoner's release are marked by very high mortality rates, especially drug-related deaths (23).

Mortality rates among recently released Aboriginal prisoners in New South Wales are higher than non-Aboriginal prisoners. A Western Australian study also found lower survival rates among female and male Aboriginal prisoners (22). Suicide, motor vehicle accidents, circulatory system diseases and drug-related deaths were the most likely causes (22). Evidence suggests hospitalisation rates among recently released prisoners are also higher among Aboriginal people, and the consequences go beyond those to the individual, their family, friends and community. Hospitalisation of Aboriginal prisoners within 12 months of their release is estimated to have cost more than \$5 million between 2000 and 2002 in Western Australia alone (24). The cost of hospitalising Aboriginal prisoners in Victoria is discussed further in 6.2.2.3. As that and it is evident by making transition work for Aboriginal prisoners will save many lives and obviate an unnecessary source of family and community grief and loss.

Many ACCHOs' health and mental health services meet the cultural, health and specific needs of Aboriginal former prisoners listed within Key Requirement 1.1.4 of Justice Health's Policy and Quality Framework. Aboriginal former prisoners may be unable to access a general practitioner for a new prescription or a psychologist or psychiatrist to assist with mental health problems without planning and ACCHOs are not presently offered the opportunity to plan such services in the risky transition period. ACCHOs were confident these services could be arranged to meet Aboriginal prisoner needs with adequate time. A number of transition models that link Aboriginal prisoners to post-release support are discussed in 6.2.2.1.

A lack of planning also engenders safety concerns for former prisoners, staff members and community when people with mental health problems present. In one example, imperturbable ACCHO staff members identified serious safety concerns not long after a former prisoner sought health care. The person had been taken off mental health medication in the lead up to release and presented at the ACCHO without an appointment. Staff members recognised a problem before the situation escalated and later discovered the former prisoner had significant mental health problems and was under strict parole requirements. The example serves to highlight the consequences of poor communication, planning and continuity of care, which can lead to major incidents, hospitalisation, and worse. This event is perhaps what Recommendation 152(e) of the RCIADIC had in its sights:

That Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon, the following matters together with other matters thought appropriate:

- e) The exchange of relevant information between prison medical staff and external health and medical agencies, including Aboriginal Health Services, as to risk factors in the detention of any Aboriginal inmate, and as to the protection of the rights of privacy and confidentiality of such inmates so far as is consistent with their proper care (6)*

Identifying post-release pathways was recommended as one of five research priorities by an Industry Roundtable held by the Cooperative Research Centre for Aboriginal Health, the Public Health Association of Australia and the Australian Institute of Aboriginal and Torres Strait Islander Studies. The group identified a need to "[u]ndertake an audit of the scope of health services in custodial settings and the current models of service delivery mechanism in prison, with a focus on pathways for continuity of care pre- and post-release" (46). This should be encouraged, although an action research approach would be apposite, in partnership with ACCHOs and potentially other organisations. However, prison health services can immediately begin increasing access to post-release health and mental health support by establishing partnerships with ACCHOs to support basic health and mental health needs of Aboriginal prisoners.

6.1.3.2 Post-release appointments

Almost all ACCHOs identified pre-release transition planning as a prerequisite to improving Aboriginal prisoner health. In addition to health services, many ACCHO programs such as family counselling, healing services, and men's groups address mental health and have practical relationships with external services including local Police and Sheriff offices that deal with outstanding warrants and infringements notices that remove pathways back to prison.

Reintegration poses many problems for former prisoners as well as their family, friends and local community. Most ACCHOs appealed for time to plan prisoner release so that services could be coordinated to meet individual needs. Some services offered by ACCHOs are only available on certain days but could be coordinated with enough time.

ACCHOs were seldom made aware of a prisoner's release and never through a post-release appointment made by a prison health service, instead finding out through the Koori grapevine and ALOs, if at all. Prison health service staff members identified two barriers that affect whether a prisoner had a post-release appointment arranged: feelings of shame for being in prison and a self-perception that they were healthy and therefore did not need a health care appointment. Support workers have overcome these barriers by building trust with Aboriginal prisoners prior to their release and by developing tailored responses to each person – for example, accompanying former prisoners to their initial ACCHO appointment.

Relationships between ACCHOs and prison health services would result in better planning, with some ACCHOs suggesting alternative arrangements to support Aboriginal former prisoners' transition back into the local community. Suggested arrangements included meeting in a safe space away from the service with an ACCHO worker. One interviewee suggested recently released prisoners could have their initial consultation in a safe, neutral environment like family and counselling services or a mainstream partner. Some larger ACCHOs could host post-release appointments in separate buildings and bring in the requisite health or allied health workers as well as social support services if necessary.

6.1.3.3 Health record transfer

A major part of the prisoner transition process includes transferring a prisoner's health history to non-prison services involved in the person's care. Prison health services perform this task by preparing a discharge summary, which is provided to the prisoner and a copy kept on file.

Some ACCHOs, ALOs and AWBOs felt the transfer and continuity of health records needed to improve substantially at both reception and release. Some participants were frustrated at the large number of duplications in the process, particularly related to mental health assessments, which could be repeated up to three times between arrest and release causing prisoners to relive traumatic events (as highlighted in 6.1.1.2).

ACCHOs reported rarely seeing health and mental health discharge summaries and of those that do, most described them as inadequate, inconsistent, and lacking in detail (not enough "between the lines" information). No specific information was identified, however improving partnerships and dialogue between prison health services and ACCHOs would be a good first step in defining what "between the lines" information was lacking. No ACCHOs had seen a discharge summary prior to meeting with a former prisoner. A lack of health record preparation before parole and court release hearings further degraded the information transferred to non-prison support services. Staff members felt the lack of communication not only put staff members in a potentially unsafe situation, but also created an environment where the former prisoner was set up for failure. Without processes facilitating prisoner health information continuity of care is affected, and as highlighted by the example in 6.1.3.1, can raise safety concerns.

6.1.3.4 Opioid substitution therapy

Prison health services and ACCHOs struggle to find post-release places for prisoners receiving opioid substitution therapy (OST), particularly outside Melbourne, probably driven by Victoria's claim to the highest number of clients per dosing point in Australia (47). The lack of access to OST was reiterated by ALOs and AWBOs. Responsibility for the OST system is with the Victorian Government Department of Health once prisoners are released.

Interviewees cited two barriers to enrolling prisoners in pharmacotherapy programs: a lack of opioid-dispensing sites without waiting lists, and a previous incident where the prisoner had been banned (sometimes due to one-strike policies enforced by the pharmacy) – a barrier also identified by other organisations (48). These barriers impact the supply chain before the prisoner is released by increasing time spent by prison health workers arranging post-release appointments with opioid-dispensing pharmacies. One prison health service described a staff member spending an entire shift locating a pharmacy willing to accept the soon to be released prisoner.

The real impact of poor OST access is felt by prisoners however. Appointments are often in locations that add unnecessary travel time and financial costs creating unreasonable, unsupportive and unsustainable burdens. People are forced to travel long distances daily – often to Melbourne from Bendigo, Shepparton, and Ballarat to receive treatment. A support worker sometimes accompanies the person, further illustrating the supply chain flow-on effects. A lack of program affordability is a major contributing factor to the acrimony between pharmacists and OST clients that leads to the dispenser refusing access (49). Justice Health funds the first 30 days of post-release OST, however use of this relies on the pharmacy being accessible to the recently released prisoner.

The benefits of a 21% increase in dosing points between 2006 and 2011 have been erased by a 22% increase in clients (47). Over 90% of clients receive OST at pharmacies however less than 40% of pharmacies are OST dispensers (47,49). A review of the Victorian pharmacotherapy system recommended increasing access to OST in rural and outer metropolitan areas, increasing support and incentives for pharmacies, making OST-dispensing compulsory at all pharmacies, encouraging private clinics to prescribe and dispense, establishing outreach prescribing and establishing dispensing buses for rural areas (49). Enacting these recommendations would likely improve former prisoner outcomes and quality of life.

Victoria is the second highest per capita dispenser of OST nationally with almost 14,000 clients in 2011 – a 158% increase since 1998 – however statistics do not routinely identify Aboriginality (47). National statistics are also afflicted by poor identification, however of available statistics Aboriginal people are almost four times more likely to be enrolled in OST than non-Aboriginal people (47). Aboriginal prisoner enrolment in OST varies across Australia, with a NSW study identifying higher rates among Aboriginal prisoners (11), while a national prison entrants survey found lower rates, although this was skewed by very low rates in the Northern Territory (4). Without Victorian-specific data it is difficult to plan and respond to Aboriginal prisoner needs and as a consequence continuity of care is affected because services are unable to develop an efficacious, evidence-based plan. The Victorian Ombudsman found OST was under-resourced in Victorian prisons and affecting prison transfers (31). This inadequacy will have greater consequences for Victorian Aboriginal prisoners if OST rates mirror those in New South Wales (31). There is no publically available evidence on the number of Aboriginal people receiving OST in prison. Reporting on the health of Aboriginal people in prison, including OST participation, would significantly improve planning among Victorian ACCHOs as well as mainstream health services.

6.2 Part two: Relationships between ACCHOs and prison health

6.2.1 Relationships between ACCHOs and prison health services

Prison health services can play an important role in connecting Aboriginal prisoners with ACCHOs, however this study found this opportunity is not taken. Unlike other jurisdictions where 21% of prisons received medical-related visits from an ACCHO or Aboriginal Medical Service⁸ at least every two weeks (4), there were only two instances of ACCHOs being involved in any level of service delivery with Koori prisoners. The first was a one-off relationship between the Victorian Aboriginal Health Service and Dame Phyllis Frost Centre, where one female prisoner received dental services. The second was an AHW at Ballarat and District Aboriginal Cooperative (BADAC) accompanying community elders on several visits to a nearby prison. The latter, a relationship that did not involve the prison health service, led to a positive post-release engagement with BADAC (as described in 6.2.3).

ACCHOs were re-engaging Aboriginal former prisoners in a randomised manner rather than a scheduled medical appointment organised by a prison health service. Most said that prisoners re-engaged through the ACCHO's peripheral social services (e.g. opportunistic adult health checks in men's groups, housing assistance, etc.). ACCHOs pointed out they assist people with Centrelink, housing and employment, and also provide psychology, psychiatry, counselling, general practitioner, nutrition, and many other services that prisoners could benefit from. These are not 24 hour, seven days a week services, and in some cases might only be offered once a fortnight. ACCHOs were confident with enough time to plan, services could be coordinated for former prisoners. However most prisoners do not access these services soon after release, meaning that continuity of care is impaired in the most dangerous period.

ACCHOs felt their capacity to play a role in mitigating the higher risk of death and hospitalisation among recently released prisoners would improve through better relationships with prison health services. Both prison health and ACCHO workers expressed a desire to develop a relationship, however low awareness of one another exists. Almost all prison health services had little understanding of the role and capabilities of ACCHOs in the Victorian health system and were surprised by the number and diversity of services offered. The lack of contact and relationships between prison health services and ACCHOs was reiterated by ALOs and AWBOs.

6.2.2 Potential ACCHO involvement in health care for Aboriginal prisoners and benefits

Improving health-related outcomes for Aboriginal prisoners will require high level leadership and commitment from Corrections Victoria, Justice Health, prison health services, ACCHOs and other areas of government. An already high workload seemed to dampen motivation, with interest tepid and equivocal. Interviewees' first response was to raise challenges, commonly that most people released from prison do not remain in the region and therefore a relationship with the local ACCHO would not lead to benefits. A lack of time and resources was raised by both prison health services and ACCHOs as another barrier, and some talked of poor previous relationships (some ambiguous relationships between some prison health services and ACCHOs existed several years previous). Despite the barriers there is no evidence that suggests a health-care relationship would not improve post-release outcomes. Further, it is incumbent upon prison health services to consult with ACCHOs to improve health service delivery and transition processes as documented in Key Requirement 2.1.15 of Justice Health's Policy and Quality Framework:

The Service Provider undertakes consultation with Aboriginal Community Controlled Health Organisations to enhance and further develop health service delivery for Aboriginal and Torres Strait Islander Patients/Clients across the Victorian prison system, and to support connection and engagement upon transition to the community. (33)

Justice Health implicitly acknowledges the benefit of bringing community services into prison to improve continuity of care among Aboriginal prisoners. The Aboriginal and Torres Strait Islander health

⁸ An Aboriginal Medical Service (AMS) is not necessarily community controlled.

discussion in Section 3.2.3 of the Justice Health Policy and Quality Framework lists recommendations made by the Australian National Council on Drugs (ANCD), including support to “[p]rovide a continuum of healthcare and referral both within and beyond the corrections system by allowing Aboriginal and Torres Strait Islander health and medical services access to prisoners” (33). Section 3.2.3 also cites the ANCD report’s encouragement for the corrections system to “(c)ontract or develop partnerships with Indigenous services such as Aboriginal community-controlled health services and Aboriginal drug and alcohol services to work in correctional centres, especially where there is a significant population of Indigenous offenders” (45).

Anecdotally, the presence of an Aboriginal Hospital Liaison Officer (AHLO) at Port Phillip Prison each fortnight was having a positive effect on access among Aboriginal prisoners. The AHLO has a much better understanding of the health system than the prison Aboriginal Liaison Officers (the AHLO is based in St Vincent’s Hospital and has significant knowledge of and connections with the ACCHO sector). However with just one day a fortnight and Port Phillip Prison’s high turnover and large number of Aboriginal people – 71 in March 2012 (13) – the benefits of the role are impaired. Understanding each prisoner’s history and developing rapport is very difficult when the AHLO may only meet them once before the prisoner is transferred to another prison. The prison health service attached high value to the role and brought up an unsuccessful request for additional funding to increase the AHLO’s hours at the prison. Port Phillip Prison is the only model in the Victorian prison health system where an Aboriginal person is (somewhat) involved in health care. The prison health service, ALOs and AWBOs identified the role as a benefit to Aboriginal prisoners, although both desired a much greater presence. Whilst the role should not serve as a model for other Victorian prisons, there are lessons and experience held by the AHLO and Port Phillip Prison that would inform future Aboriginal health roles in the Victorian prison health system.

6.2.2.1 Potential models for ACCHO involvement in prison health

This study found that present prison health policy guidance is not effective at linking Aboriginal prisoners with ACCHOs upon their release. Given the growing number of Aboriginal prisoners and the high social and economic costs to people, communities, and government it is in Victoria’s interest to improve post-release outcomes for Aboriginal prisoners. Employing people and new models in Aboriginal prisoner transition is necessary to improve outcomes.

Most ACCHOs, ALOs and AWBOs felt prison health services should refer Koori prisoners to ACCHOs on release wherever possible. Almost all people interviewed believed involvement of Aboriginal workers pre-release through to post-release is necessary if prisoners are to be engaged with a health service after their release. ACCHOs repeatedly raised the need for early involvement in prisoner release planning, and one person suggested jointly developing a pre-release checklist for all Aboriginal prisoners as a first step.

No tailored models of health care for Aboriginal people in Victorian prisons were found in this study, however models operating in the ACT, Western Australia, Queensland and a community health prison transition model in San Francisco offer working examples and help lead the way for Victoria to develop its own model.

In the ACT the Aboriginal prison health care model jointly developed by Winnunga Nimmityjah Aboriginal Health Service and the Alexander Maconochie Centre in the ACT has been operating since 2008. The model sees a doctor from the ACCHO attend the prison with an AHW, with the latter visiting two other days each week. The AHW participates in non-health activities such as art classes and also attends pre-release meetings with other support organisations and is involved with case management (50). This prison health care model is similar to the model recommended by the Australian National Council on Drugs’ National Aboriginal and Torres Strait Islander Drug and Alcohol Committee cited within Justice Health’s Policy and Quality Framework on Aboriginal and Torres Strait Islander health (33). While it is too early for the model to report on changes to access and engagement, health outcomes, and recidivism among Aboriginal former prisoners, this is a potential model of care.

The Western Australian model focuses on transition health outcomes and is promoted as an Aboriginal health re-entry program (51). ACCHOs and other health organisations across the state are contracted

to provide health transition assistance before and after Aboriginal prisoners are released. The model is funded over four years with \$7.2 million from the Western Australian Government Close the Gap initiative and managed by the Western Australian Department of Health Country Health Service. The model relies on Aboriginal prisoners volunteering and prison health services actively taking part. A range of prisoner data is reported monthly and matched to data collected by the Department of Health. Referral rates in the 18 months of operation were 24% however this figure belies the variation among individual prisons, with some achieving a 100% referral rate while other prisons were very low, one was just 3% (52). While the program has not completed a formal evaluation, anecdotal accounts and ongoing monitoring of service data suggest that a narrow focus on clinical health outcomes has led to low referral numbers among the Aboriginal prison population. A greater focus on holistic health care needs and increasing the role of health re-entry services before and after release was identified as an opportunity to improve post-release outcomes, while strong relationships between prison superintendents and the transition health program seemed to be related to much higher referral rates. Workers that developed relationships with Aboriginal prisoners prior to release also appeared to engender greater post-release service engagement. It was also observed that the health re-entry approach for Aboriginal prisoners should be embedded in existing systems.

A large randomised controlled trial of a health-based intervention for 1,500 recently released prisoners in Queensland is also demonstrating positive outcomes. Prisoners involved in the *Passports to Advantage* project were comprehensively assessed prior to their release and an intervention group received detailed, structured feedback on health and psychosocial needs and a 'passport' of services at their release tailored to their specific needs (53). Those in the intervention group received facilitated access to health and social service after their release. In the four weeks after release – recognised by the study authors as a critical time for health needs – the intervention group received weekly phone calls. Access to a toll free number for help with referrals and general support was available for six months after release. Evaluation was based on follow up interviews held at 1, 3 and 6 months and access to individual Medicare and correctional data for two years after release. The study authors had not published the results of the project at the time of writing, however preliminary results are encouraging with increased general practitioners and mental health service utilisation among those in the intervention group (54). Further, early contact with primary care appears associated with subsequent mental health service contact (54). Given the very high rates of mental illness among Aboriginal prisoners, these results are encouraging.

Evidence of positive post-release health outcomes among prisoners with previously poor health access have been found within a model developed in San Francisco. The Transitions Clinic in San Francisco targets the health needs of recently released prisoners with chronic health conditions (including substance abuse) and their families. The model began with the employment of a full time community health worker (CHW) in a community health service with a caseload of 30 – 40 patients. The CHW attended pre-release parole meetings and offered to schedule a transitional health care appointment within two weeks of each prisoner's release (55,56). In its first 18 months of operation the program increased health service engagement and six month follow up rates by 15% and 30% respectively, and engaged a disproportionately high number of people from a minority background (56). Transition Clinic clients visited the Emergency department 51% fewer times than prisoners receiving expedited care (and presumably much fewer than no intervention, as is the case in Victoria) (55,57). The program now employs two CHWs and a physician two days per week (a nurse practitioner's salary is covered by the community health service) and costs approximately US\$200,000 per annum (57). The clinic has established a Transitions Clinic Network that collaborates and supports clinical sites in the United States and Puerto Rico, including Indigenous communities, in their development of transitional clinical programs (58).

6.2.2.2 How an Aboriginal transition health model could work in Victoria

A transition health model in partnership with ACCHOs for Aboriginal prisoners in Victoria could sit well given ACCHOs' social support services closely mirror services offered in the ACT, WA and the Transitions Clinic. The start-up costs would be relatively low if the model was based in an existing service and would likely see health cost savings (as described in 6.2.2.3) exceed associated program costs. A specialised Aboriginal Health Worker – a similarity shared by models described in 6.2.2.1, with the

Transitions Clinic employing a community health worker with a history of incarceration – employed in an ACCHO that works in collaboration with other prison transition support services to build relationships with prisoners prior to their release would tailor the program to individual needs. This individual approach has been identified as the first theme among successful comprehensive disease management programs that reduce avoidable hospitalisation (59), and is supported by the preliminary findings of the Queensland study described in 6.2.2.1. ACCHOs are located within 55km of all Victorian prisons meaning geographical distance is not a significant barrier, however the loss of a health worker or a doctor for a day would have consequences for the ACCHO and its ability to meet community demand. ACCHOs pointed out that a reasonable level of funding would be required to operate such a model. This arrangement must augment not usurp prison health services' cultural competency obligations under Justice Health's Policy and Quality Framework. It would also need to be fully integrated with and complement transition support services funded by Corrections Victoria.

Any transition health model needs to be carefully implemented based on evidence-based practice and its outputs and outcomes regularly monitored and reported on. In the United States another transition program, albeit not health-specific, resulted in higher rates of re-arrest and recidivism post-intervention when compared to non-participants (60–62). Project Greenlight combined cognitive behaviour therapy with assistance on employment, housing, family counselling, drug education, practical skills, parole conditions, and an individualised release plan (62). The duration of evidence-based interventions was shortened and the size of groups increased to fit into the program and subsequent evaluations found particularly poor outcomes among medium and high risk offenders (61). Anecdotally Aboriginal prisoners are more likely to be in these high risk categories, so it is essential that any transition health program does not exacerbate already poor post-release outcomes. Any intervention must be of appropriate length, especially given longer treatment duration is associated with better outcomes for behaviours such as drug abuse in both prison and non-prison populations (63,64). Attention must also be made to gender. A comprehensive evaluation of a nationally funded re-entry initiative in the United States, found interventions worked differently for males and females (65). These evaluations offer important lessons when developing a transition health program and evaluation must focus on health-related outcomes agreed by both Justice Health and the Victorian Aboriginal community that incorporate holistic health needs and findings from this report including for example post-release morbidity and mortality, follow up of unmet health needs (described in 6.1.2.4) post-release, reasons for drop out or no follow-up, and transfer of prison health history and continuity of care and treatment. Data collection must not simply collect and report on the opinions of participants and staff members, which Project Greenlight demonstrated to be inaccurate measures to predict poor post-release outcomes (60).

6.2.2.3 Benefits of improving post-release Aboriginal health outcomes

Health programs focused on prisoner transition have increased post-release health care access and reduced hospitalisation and repeat hospitalisations of recently released prisoners (55,56). Achieving these outcomes would not only improve quality of life for Aboriginal former prisoners and their families but obviate significant health costs for the Victorian government, especially given hospitalisation rates among Aboriginal prisoners are so high (see Table 3). Hospitalisation of recently released Aboriginal prisoners in Western Australia directly cost the State and Federal governments \$5.4 million between 2000 and 2002 (approximately \$8.5 million in 2013 dollars⁹) (24).

9 Assuming health cost increases of 4.5% per annum – a conservative figure based on Australian Bureau of Statistics Consumer Price Index data

Table 3: Hospitalisation rates among prisoners in Western Australia after being released from prison

Cohort	Percentage of all prisoners released that are hospitalised (non-gynaecological) within:		
	One year (%)	Two years (%)	Five years (%)
Aboriginal men	24	37.5	57.7
Non-Aboriginal men	19.0	30.1	48.7
Aboriginal women	40.8	57.3	74.1
Non-Aboriginal women	25.8	39.1	56.1

Source: Adapted from Hobbs et al. 2006 (66)

Table 3 highlights the very high rates of hospitalisation seen among Aboriginal former prisoners. This review of hospital and prison records found the mean number of hospitalisations of Aboriginal men and women to be 3.4 and 8.0 admissions respectively *after* their first release from prison over an eight year study period (66). Given the average cost per admitted patient separation in Victoria in 2011-12 was \$4,693¹⁰ (67), and assuming similar hospitalisation rates among Aboriginal prisoners in Victoria, post-release hospitalisation costs approximately \$16,000 and \$36,000 per Aboriginal male and female prisoner in Victoria respectively¹¹ (using 2011-12 figures, which undervalues present day cost). Table 4 estimates the *direct* hospitalisation costs of Aboriginal prisoners in Victoria in their first year of release.

Table 4: Estimated direct hospitalisation costs for Aboriginal prisoners in Victoria in their first year of release

	Conservative	Realistic
Aboriginal men		
Number of people released	100	120
Hospitalisation rate (number)	24% (24)	24% (29)
Mean hospitalisations per person (total hospitalised)	2 (48)	4 (116)
Estimated cost	\$225,264	\$739,500
Aboriginal women		
Released	16	19
Hospitalisation rate (number)	40.8% (7)	40.8% (8)
Mean hospitalisations per person (total)	2 (14)	6 (48)
Estimated cost	\$65,702	\$306,000

10 "The cost per casemix-adjusted separation is a measure of the average cost of providing care for each admitted patient separation, accounting for the relative complexity of the patient's condition. It is calculated for selected public acute hospitals as the average recurrent admitted patient expenditure for each separation, adjusted using AR-DRG cost weights for the resources expected to be used for the separation." (67)

11 The admission rate for Aboriginal women includes gynaecological-related admissions and thus overstates admissions. However statistics from the Western Australian prisoner cohort (cited) indicates that the overstatement is not significant. That is, hospitalisation rates for female Aboriginal prisoners remain well overrepresented after excluding gynaecological-related admissions.

Total

Number of people released	116	139
Number of people hospitalised	31	37
Number of hospitalisations	62	164

Estimated hospitalisation costs for Aboriginal prisoners in the 12 months following release	\$290,966	\$1,045,500
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Assumptions:

Conservative – Release numbers calculation: Number of prisoners x percentage prisoners with expected time to serve less than 12 months

- (i) Prison numbers: 331 Aboriginal men, 28 female (68)
- (ii) Percentage prisoners with expected time to serve less than 12 months: 30.7% Aboriginal men, 57.9% Aboriginal women (June 2010 figures) (2)
- (iii) Mean hospitalisations per person: Taken from WA prisoner study. No figures based on one year post-release, however mean hospital admissions per prisoner post-release over study period was: 6.5 per admitted Aboriginal male, 10.4 per Aboriginal female (66). Conservative figure of 2.0 visits in first year per person hospitalised based on these figures.
- (iv) Cost per admission: Based on 2011-12 average cost of \$4,693 per patient separation in Victoria (67)

Realistic – Release numbers calculation: Number of prisoners x estimated number of prisoners released in 12 month period

- (v) Prison numbers: 331 Aboriginal men, 28 female (68)
- (vi) Estimated number of prisoners released in 12 month period: Percentage prisoners with expected time to serve less than 12 months + 20% (to compensate for people imprisoned for short periods multiple times in one year).
- (vii) Mean hospitalisations per person: Taken from WA prisoner study. No figures based on one year post-release, however mean hospital admissions per prisoner post-release over study period was: 6.5 per admitted Aboriginal male, 10.4 per Aboriginal female (66). Risk of hospitalisation assumed to be higher in the first post-release year, mean hospitalisations in first year per person estimated to be 60% of mean hospitalisations across the WA prisoner study period. Based on higher rates of hospitalisation and mortality in first year post-release seen in many studies (23,25,66).
- (viii) Cost per admission: Estimated to be \$6,375 per patient separation based on 2011-12 average cost of \$4,693 per patient separation in Victoria plus the 30% Aboriginal WIES supplement plus 4.5% health cost inflation (67,69)

The cost estimations in Table 4 demonstrate the significant health cost savings to the Victorian government by preventing hospitalisation among recently released Aboriginal prisoners. The savings would likely increase given these figures do not account for the higher mortality and morbidity rates experienced by Aboriginal former prisoners (i.e. those out of prison longer than one year), nor many other direct and indirect individual, family and society costs (e.g. non-hospitalised health care, mental health, substance misuse, social services, etc.). Increasing health-related support for Aboriginal prisoners with health, mental health, and substance abuse problems could also reduce imprisonment rates given the positive association that such conditions have with recidivism and criminal activity (29). However it is not VACCHO's view that transition health and recidivism outcomes should be linked. A transition health model's goals should focus on improving health and mental health-related outcomes and access to appropriate services in the first 28 days to 12 months where morbidity and mortality rates are much higher and there is evidence (supported by the preliminary findings of the Queensland study described in 6.2.2.1) that service engagement can be increased during this period.

6.2.3 Relationship between ACCHOs and prisons (non-health)

Relationships between prison health services and ACCHOs are undeveloped, however all ACCHOs interviewed have non-medical relationships with at least one prison, usually organised through the prison ALO. The frequency of contact varies, some ACCHOs visited monthly or bi-monthly while one smaller ACCHO visited annually. Most relationships are with the closest prison or prisons and many also visit youth detention centres. Prison health services and ACCHOs both spoke of Aboriginal-specific programs offered in prisons, which several ACCHOs participate in during their visits.

ACCHO prison visits are viewed as a connection to community that supports Aboriginal prisoner social and emotional wellbeing. Visits are usually attended by community elders and leaders as well as local justice workers rather than Aboriginal Health Workers, although there were instances of the latter. An Aboriginal Health Worker from Ballarat and District Aboriginal Cooperative participated on monthly visits for six months beginning in 2011, which led to greater continuity of care post-release. In one example the AHW developed a relationship with a young Aboriginal man during a prison art program, contemporaneously raising the prisoner's awareness of the ACCHO's services. After the man's release he visited the ACCHO, linked up with the AHW who also connected him to other ACCHO's services, and helped exhibit the client's art which was identified as a big boost to that person's confidence and non-prison connections. The example highlights the benefits of pre and post-release continuity and how ACCHOs' holistic service assists prisoners' reintegration. It also demonstrates the importance of AHWs being involved in activities outside health care, which is recognised within the prison health care model created by Winnunga Nimmityjah Aboriginal Health Service and the Alexander Maconochie Centre.

ACCHOs self-fund prison visits, and some do not limit their geographical reach, with examples of workers travelling hundreds of kilometres to meet with a community member in prison. ACCHOs quickly identified the cost and capacity constraints that sending health workers into prisons places upon the health service. In the above example from Ballarat, the ACCHO was considering sending a newly employed male mental health nurse on prison visits, however the decision was weighed heavily by limited staff resources. The loss of a health worker reduces the number of client consultations at the ACCHO on the day, which impacts on the local community and may reduce revenue streams. Nonetheless just as other studies have reported (70), creating links between a prisoner and their family and local community is considered best practice for reintegration programs and policies, which ACCHOs are best placed to deliver for Aboriginal prisoners.

6.3 Other themes

A number of themes outside the project's scope arose from interviews, some of these are discussed below. There are many problems, and presumably some strengths, that remain unaddressed and in need of improved community consultation, greater transparency, and systematic and continuous quality improvement. A focus on improving data quality and availability and requiring external accountability would provide a solid base for these changes to occur.

6.3.1 Social support

First and foremost in discussions with ACCHOs was a lack of housing and income (particularly employment pathways). Homelessness, a lack of housing options and overcrowded housing have been highlighted in the past (71), however it remains a significant barrier to reintegration. ACCHOs identified long waiting periods (up to two years) as drivers of anxiety and frustration, with many directing these feelings toward ACCHOs who are powerless to increase housing options, let alone on the scale needed.

Most ACCHOs hoped for more financial resources so they could employ outreach and on-call workers to meet frequent out-of-hours' needs. Local justice workers and AHWs often accommodate requests that are outside the responsibilities and expectations of their role are very high. Most respond to requests at any time of the day and week to help people recently released from prison, paroled, or released at court for no material reward. During one interview a worker received an SMS from a client that had previous justice system contact. The unperturbed worker nonchalantly conveyed that people often send a text message or email just to keep in touch.

A lack of immediate access to alcohol and other drug detoxification and rehabilitation options in the community was thought by ACCHOs to result in relapse and missed opportunities to harness motivation. Waiting times of six weeks and few family friendly options based away from home were attenuating client motivation by condemning substance abusers to return to and wait in the same environment that nurtured their addiction. This inevitably led to relapse despite the best intentions.

6.3.2 Communication problems

All people interviewed identified an absence of inter- and intra-sector communication as a pervasive affliction upon the prison system. The absence of relationships between ACCHOs and prison health services is just one example of a vast prison system that appears incredibly fragmented with complementing services operating in isolation from one another. Some examples include a lack of communication between Justice Health and ALOs and AWBOs who sometimes act as a conduit between the prison and the prison health service. ALOs and AWBOs often lack basic understanding of the health system and how it works, with one ALO frustrated that prisoners could not access Medicare at their prison. One prison health service felt that occasional involvement in Koori prison programs would assist in building rapport with Aboriginal prisoners and facilitate greater engagement.

Communication breakdowns are not exclusive of prison health. Some prison health services are not informed of health-related prison programs. In one example, the prison health service was not made aware that the prison was hosting a Hepatitis C discussion delivered by an external organisation. The prison health service was unprepared for the sudden rise in prisoners requesting testing and discussing the disease.

6.3.3 Administration burden

Many ALOs and AWBOs felt there was a heavy administrative burden placed upon ALOs and AWBOs as well as the prisoners they work with. Prisoners were often reluctant to provide formal consent which encumbered successful engagement with ALOs/AWBOs. Navigating and adhering to bureaucratic processes were viewed as unnecessary barriers to engagement.

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8 Appendices

Appendix 1 – Interview guides

ACCHOs

Introduction

VACCHO began working with the Department of Justice and Monash University on a project last year to improve mental health services for Koori people in Victorian prisons as part of the second Aboriginal Justice Agreement. That project continues, with about 90 interviews completed.

VACCHO is also working with the Department of Justice on a related project. VACCHO is talking to members and prison health services to gain an understanding of the systems in place within the prison system for Koori people to ensure continuity of care among Koories in contact with the prison system.

Interviews are recorded with full transcript editing rights offered to interviewees.

Study Purpose:

To investigate the systems in place within goals to ensure continuity of care for Koori clients in prisons.

Overall Study Question:

How can continuity of care be enhanced for Koori clients in prison?

Question guide – ACCHO (GP, Practice Manager, Senior AHW)

Question	Notes
<ol style="list-style-type: none">1. How are Koori client records transferred to prison health services?<ul style="list-style-type: none">• How do you become aware of a Koori client entering the prison system?• How do you contact and collaborate with other health providers that the client has accessed to ensure a complete client health record is provided to prison health services?• What processes are undertaken to ensure continuity of care for Koori clients entering the prison system?2. How do you ensure continuity of care for Koori clients in prison?<ul style="list-style-type: none">• How is contact maintained with prison health services to ensure continuity of care for Koori clients?• What kinds of difficulties are encountered in ensuring continuity of care for Koori clients within the prison system?• How might these difficulties be overcome?3. How is client monitoring, follow-up and continuity of care ensured for Koori clients on their release from prison?<ul style="list-style-type: none">• How does the ACCHO become aware of someone being released from prison?• How does the ACCHO become aware of the patient's most recent medical history?• How does the ACCHO offer services to Koori clients recently released from prison to ensure continuity of care?• How might continuity of care for recently released Koori clients be enhanced?4. How might this ACCHO provide improved services to Koori clients in prison?<ul style="list-style-type: none">• What additional services might ACCHOs offer to Koori clients in prison to ensure continuity of care?• How would these services be developed and delivered?• What resources would be required?• What additional factors need to be considered regarding establishing partnerships between ACCHOs and prison health services to ensure continuity of care for Koori clients?5. Is there anything else that you feel is important to say?	

Additional information and/or actions

- Ask for copies of any prison health-related services documents (e.g. brochures, posters, reports, etc)

Prison health services

Introduction

VACCHO began working with the Department of Justice and Monash University on a project last year to improve mental health services for Koori people in Victorian prisons as part of the second Aboriginal Justice Agreement. That project continues, with about 90 interviews completed.

VACCHO is also working with the Department of Justice on a related project. VACCHO is talking to members and prison health services to gain an understanding of the systems in place within the prison system for Koori people to ensure continuity of care among Koories in contact with the prison system.

Interviews are recorded with full transcript editing rights offered to interviewees.

Study Purpose:

To investigate the systems in place within goals to ensure continuity of care for Koori clients in prisons.

Overall Study Question:

How can continuity of care be enhanced for Koori clients in prison?

Question guide – Prison health services

Question	Notes
<ul style="list-style-type: none">• How do you access a Koori client’s health history?• What kind of difficulties have you experienced in accessing Koori client’s health records?• How could these processes be enhanced?• How do Koori clients first come into contact with prison health services?• How are Koori clients introduced to the prison health service?• How are Aboriginal images and health promotion materials used in the prison’s health service?• How are Koori clients involved in the development of their care plans?• What kind of difficulties are encountered in developing a care plan with a Koori client?• How might these difficulties be overcome?• How might AHWs from ACCHOs enhance service provision to Koori clients?• How is regular Koori client contact with prison health services maintained?• How are regular Koori client health checks ensured?• How is client recall facilitated to ensure Koori clients show up in the clinic?• What kinds of difficulties are experienced in ensuring Koori client follow-up?• How might these difficulties be overcome?• How is continuity of care ensured upon the release of Koori clients?• How is a Koori client’s health provider in the community contacted?• What is the process for handing over a Koori client’s health history?• What kind of difficulties are encountered in Koori client handover to their health services provider?• How might these difficulties be overcome?• What is known by this prison health service about the role of ACCHOs?• Do staff members receive cultural awareness training?• Do you have Aboriginal staff members?• Who does the prison health service liaise with in the local ACCHO?• How are the services of ACCHOs utilised by prison health services?• How might this prison’s health services for Koori clients be enhanced by partnership with a local ACCHO?• Is there anything else that you feel is important to say?	

Additional information and/or actions

- Ask for copies of any prison health-related services documents (e.g. brochures, posters, reports, etc)

Appendix 2 – Position description: Aboriginal Liaison Officer / Aboriginal Wellbeing Officer

Position of Aboriginal Wellbeing Officer / Aboriginal Liaison Officer advertised by Port Phillip Prison operator, G4S Australia Pty Ltd, April 2012.

<p>Roles and responsibilities</p>	<ul style="list-style-type: none"> • Provide information, support, advice and assistance to Indigenous prisoners • Assess Indigenous prisoners as soon as is practicable following reception, aiming to provide information regarding available Indigenous-specific programs and services and facilitating appropriate referrals as necessary • Provide information, support, advice and assistance to staff managing Indigenous prisoners • Have active involvement in the preparation, organisation and facilitation of Indigenous-specific events such as NAIDOC • Assist in the case management of Indigenous prisoners • Liaise with prison management and contract managers to maximise the streamlining of services and transition • Assist Indigenous prisoners in their preparation for release and in relation to their social welfare needs such as accommodation, social contacts, finances, contact with children, etc. and/or facilitate appropriate referrals to address these issues • Assist in the development and facilitation of Indigenous-specific programs and services • Liaise with Peer Listeners/Stabilisers/Mentors to ascertain any Indigenous issues and urgency of need • Provide cultural awareness training to correctional and support staff when requested • Assist in the identification of training needs for prison staff and liaise with the Manager, Offender Services, Aboriginal Wellbeing Officer and the Training Coordinator regarding the way in which these training needs may be met
<p>Key candidate requirements</p>	<ul style="list-style-type: none"> • Demonstrated knowledge of Indigenous social welfare issues and rehabilitative needs • Demonstrated knowledge, skills and experience in administration, record keeping, and file maintenance • Experience in working in a correctional environment would be preferred • Demonstrated experience in personal time management • Demonstrated ability to work effectively and contribute in a multidisciplinary team environment • An understanding of the criminogenic needs of offenders • A demonstrated understanding of program requirements to suit a range of complex needs populations within a correctional facility • Knowledge of MS Office applications • Displayed behaviours aligned to G4S Value and Mission statements • Demonstrated ability to plan, implement, facilitate and evaluate programs • A high level of interpersonal and conflict resolution skills • The ability to show initiative, creativity and responsibility in a challenging environment • The ability to liaise with a wide range of community, specialist and management groups • The ability to work under pressure and to work with limited supervision • Flexible and responsive to change • Tertiary qualifications in the social science and/or criminal justice fields from an accredited educational institution would be preferred

Source: G4S website (41)

Appendix 3 – Themes emerging from interviews



Keeping our mob healthy in and out of prison

Exploring Prison Health in Victoria to Improve Quality, Culturally Appropriate Health Care for Aboriginal People