Primary health care services better meeting the health needs of Aboriginal Australians transitioning from prison to the community

SPRINT final report

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This primary health care and criminal justice project involved a partnership between the University of New South Wales, the Aboriginal Medical Service Western Sydney, the University of Western Sydney, the University of Technology Sydney and the NSW Justice Health and Mental Health Network.

The project was designed with input from Aboriginal and non-Aboriginal chief investigators. The research team included academics, primary health care providers, policy officers, an Aboriginal social worker and a criminologist.

Kathy Malera Bandjalan was employed as the Research Officer on the project and was instrumental in the development of the project name and logo and in the implementation of the research. Cultural brokerage was also a large part of Kathy’s role. Practically cultural brokerage helped identify whom to interview, how to break down the barriers with participants and to relate and build trust with participants.

The project was called SPRINT which stands for Services and Primary health care needs for Recently released Inmates in Need of Treatment and health management. The logo, which can be found on the front page of the report, is in the shape of a running shoe and reflects the fact that running shoes are commonly sought after by many Aboriginal people in prison.

Particular thanks to Julian Trofimovs who conducted the statistical analysis for the linked data set and Chandni Joshi searched the literature and conducted the data extraction for the systematic literature review.

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Background

THE SPRINT PROJECT

In this report we describe the factors influencing Aboriginal Australians’ access to primary health care on release from custody and we suggest ways to increase access to effective primary health care for Aboriginal people in contact with the criminal justice system.

The aim of the SPRINT project was to develop and bring to the fore culturally specific understandings of how primary health care services can better meet the health care and social support coordination needs of Aboriginal Australians transitioning from the criminal justice system into the community, with a view to reducing reincarceration and improving quality of life.

Our specific objectives were to:

> identify the health and social needs of Aboriginal people on release and in transition to the community
> describe the barriers and enablers of their access to primary health care, and
> examine the feasibility and effectiveness of strategies to provide coordinated health care from prison to primary health care in the community.

A human rights based approach

This work was framed by a human rights-based approach to health. A human rights-based approach proved important because it focuses on those who are excluded or discriminated against and encourages Aboriginal Australians (right holders) to claim their rights from governments, institutions or services (duty bearers). The focus on the responsibilities of duty bearers and right holders helps to shed light on how Aboriginal former inmates can best be supported during the transition from custody to community and how duty bearers might develop their capacity to better meet the needs of Aboriginal former inmates during their transition to the community.

The definitions that were used throughout this report, including human rights, are described in Appendix Two.

POLICY CONTEXT

Incarceration of Aboriginal Australians

Aboriginal people are overrepresented in prison. Despite comprising only 2.4% of the Australian population, 27% of prisoners are Aboriginal [1]. Established pathways into prison for Aboriginal people include poor schooling and employment, social exclusion and isolation, poor physical and mental health, drug and alcohol issues [2], unstable housing [3] and family history of incarceration, being a member of the stolen generation, and an unsupported childhood [4]. Higher rates of incarceration among Aboriginal Australians are also suggestive of structural factors such as institutional and systemic racism [5], which can increase the likelihood of an Aboriginal person becoming incarcerated. For example, institutional racism can lead to Aboriginal people being excluded from accessing relevant and essential services [5, 6], which has far reaching negative impacts on their ability – and capability – to be thriving, independent members of society. Further, systemic racism can increase the likelihood of arrest of Aboriginal people for minor offences, and also increase the probability of a prison sentence as a result of an arrest [7-9], although this claim has been contested by the NSW Bureau of Crime Statistics and Research [10].

When compared with the experience of non-Aboriginal Australians, the nature of incarceration tends to be different for Aboriginal people in contact with the criminal justice
system. Aboriginal people are more likely than non-Aboriginal Australians to: serve shorter sentences; be placed on remand as opposed to being released on bail; and to cycle in and out of prison from a young age [11]. In NSW approximately 30% of the general prison population are on remand [13]. However this may be an underrepresentation because other publications have indicated higher figures. Most recently the Australian Institute of Health and Welfare 2012 Report on the Health of Australia’s Prisoners found that in the two week data collection period, 63% of participants were on remand [14]. Whilst there are no current figures regarding the number of Aboriginal people on remand, evidence from the Indigenous Justice Clearinghouse indicates that Aboriginal Australians have greater rates of remand and need more in the way of bail support [15]. In addition, according to the NSW Inmate Health Survey in 2009, 19% of Aboriginal men surveyed had been in custody more than seven times, compared with 8% of non-Aboriginal men surveyed. Similarly 12% of Aboriginal women surveyed had been in custody more than seven times compared with 4% of non-Aboriginal women. This cycle creates a particular type of disadvantage and contributes to a higher rate of recidivism among Aboriginal people compared with non-Aboriginal offenders [12].

A significant contributing factor to recidivism is the level of services available for people on release from prison. However, in Australia a former inmate’s access to health care and social support services such as housing varies depending on the custody conditions. If a person has been in prison or on remand (as opposed to being sentenced) or is released after serving a finite sentence (rather than on parole) then they have less access to formal post release programs in the community [5]. Without access to comprehensive health care and social support services, Aboriginal people are more likely to return to the same environments that led to their incarceration in the first place, thus contributing to higher rates of recidivism. Issues of unemployment, unstable housing, mental illness and drug and alcohol problems often remain an issue on release [16]. This is often compounded by the high emotional stress associated with adjusting back to community life and a lack of accessibility, coordination and integration among service providers on post-release matters [12, 17].

Responsibility for the health and social support needs of Aboriginal Australians in transition from prison to the community

Aboriginal Australians transitioning from the criminal justice system to the community are a particularly vulnerable group who face multiple financial and social barriers to accessing primary health care. They are often stigmatised and socially excluded [16]; there are poor linkages between health services in custody and primary health care in the community; there is a lack of trust in government services; and there is a lack of access to culturally safe primary health care services [19]. Immediate practical barriers to Aboriginal people accessing primary health care services on release include competing priorities such as finding accommodation, reconnecting with family and securing employment. Former inmates do not always have access to a Medicare Card on release and might not have money to get scripts filled.

No single agency (duty bearer) has full responsibility for supporting the transition of former inmates from prison to community in NSW. Notably – and despite their particular vulnerability to numerous risk factors on release – there is no one agency with responsibility for Aboriginal former inmates’ transition to community. Nonetheless, the official policy adopted by Corrective Services NSW for supporting transition for all former inmates is ‘throughcare’. In theory throughcare policies will address prisoner needs from their first contact with prison and will provide ongoing support and management for offenders during their successful reintegration into the community. Throughcare requires that interventions commence in prison and continue post-release.

A throughcare approach also recognises that:
reintegration requires close collaboration between multiple agencies, not just correctional services

> interrelated, long-term problems often require long-term solutions

> the likelihood that interventions will produce positive outcomes can be increased by initiating services earlier in the custodial term.

Providing health care in custody and post release

In NSW, health care service provision in custody is provided by the Justice Health and Forensic Mental Health Network (Justice Health) – a statutory health corporation under the NSW Health Services Act 1997 that is funded by the NSW Ministry of Health. Justice Health cares for over 30,000 patients annually and is responsible for providing comprehensive health services in a wide variety of settings. Their goals are to: identify the health care needs of their client group; provide high quality, clinically appropriate services informed by best practice and applied research; make health care part of the rehabilitative endeavour; facilitate continuity of care to the community; develop an organisational culture that supports service delivery; promote fair access to health services and provide strong corporate and clinical governance. (http://www.justicehealth.nsw.gov.au/about-us/vision-goals-values).

The Commonwealth Health Insurance Act 1973 precludes the provision of services under Medicare or the Pharmaceutical Benefits Scheme (PBS) if these services are provided by state or territory governments. This means that prisoners are excluded from Medicare and the PBS while in custody and that they miss out on some treatments such as the Aboriginal and Torres Strait Islander Health Checks. Not having access to Medicare also provides a disincentive for community health service providers to provide in-reach services [18] and can be a barrier for inmates’ timely access to external health services on release.
Methods and results

This mixed method study had three phases: a systematic review, in-depth interviews and a linked data set analysis. Each of the methods and their results are discussed in turn.

PHASE 1: SYSTEMATIC LITERATURE REVIEW

The effectiveness of primary health care and social support services in meeting the needs of Aboriginal people released from the criminal justice system

Methods

We began by undertaking a systematic literature review to understand the health and social support needs of Aboriginal people released from custody and to examine the effectiveness of in custody, pre and post release programs in providing access to primary health care and social support services for Aboriginal people upon release.

The review questions were:

1. What are the physical, mental health, substance misuse and social support needs of adult prisoners on release and during transition from the criminal justice system, with particular reference to the needs of Aboriginal people?
2. Which programs that aim to improve access to primary health care and social support and that coordinate care from custody to the community have been evaluated?
3. How effective are these programs in coordinating care from custody to the community and in coordinating access to community health and social support systems?
4. What are the barriers and enablers to implementing these programs?

We used scoping searches to identify key terms relating to Aboriginal and Torres Strait Islanders, health and post release. The criminology literature was searched via the CINCH and Criminal Justice Abstracts databases. The medical and health literature was searched via the following databases: Medline; Embase; PsychINFO and CINAHL. A general search was also conducted on Google Scholar.

Papers with research from Australia, New Zealand, US or Canada were included in the review. Papers had to be published in 2001 or later, and either be peer reviewed or from the great literature (position papers and reports). The papers needed to focus on Aboriginal people who had been in contact with the criminal justice system and needed to be based on empirical research, as opposed to opinion pieces.

1531 papers were identified in the initial search, which reduced to 950 after duplicates and papers out of the timeframe were removed. We screened the abstracts of these papers according to the inclusion criteria mentioned above. After the first screen, 212 articles were included for further review and full text articles were sought. After the second screen, 45 articles were included in the review. These papers were then read in full and grouped according to their relevance to our research questions. We used a data extraction template in Microsoft Excel to organise the information.

A narrative synthesis was conducted according to the research questions and the findings were then written up in a draft report. The draft report of the systematic literature review was circulated to the investigators for their comments and input. The findings were presented at the Justice Health and Forensic Mental Health Network Seminar Series, Long Bay, Sydney on 19 June 2013 and the Primary Health Care Research Conference in Sydney on the 11 July 2013. The systematic literature review final report is available on the APHCRI website.
Results

Health and social support needs of Aboriginal people released from custody

Of the 45 studies that were included in the review, the majority (35) described the health and social support needs of prisoners post release. Twelve papers described programs available to adults in contact with prison. All of the studies referred in particular to the needs of Aboriginal people who had been in custody.

Despite the over-representation of Aboriginal people in the criminal justice system and the high rates of illness and death among Aboriginal Australians released from prison, the review found little research evaluating the impact of programs providing access to primary health care for Aboriginal people released from custody. Even less research was available on the programs that specifically target Aboriginal people and the responsibility of corrective services, health services and non-government organisations in meeting their needs. The focus of post release services – whether delivered in custody, pre or post release – tended to address social support needs rather than health concerns specifically.

Health needs

The review found that Aboriginal people who have been in contact with the criminal justice system are likely to have multiple, long standing health issues, including those linked to substance misuse. Risk factors for chronic disease, rates of substance misuse and mental health problems are higher among Aboriginal people in custody compared with non-Aboriginal prisoners. Eighteen studies reported on the physical health needs of people in contact with the criminal justice system [11, 16, 20-35]. Eleven of these studies focused on communicable, non-communicable and chronic diseases [11, 16, 21-26, 29, 33, 35]. Four studies focused specifically on blood borne diseases [11, 25, 29, 31]. Eight studies compared Aboriginal Australians’ health needs with the needs of non Aboriginal people in custody [11, 16, 20, 21, 26, 30-32].

The 2010 Australian Institute of Health and Welfare report found that 26% of prison entrants self-reported having a current chronic condition (asthma 12%, arthritis 8%, cardiovascular disease 5%, diabetes 4%, or cancer less than 1%) [21]. Aboriginal prisoners, were more likely to take diabetic medication, anti-hypertensive and cholesterol lowering drugs [21]. Aboriginal men were more likely to report high blood pressure, high blood sugar and diabetes compared to their non-Aboriginal fellows [11, 26]. Aboriginal women scored lower on their emotional and social functioning than non-Aboriginal women [26].

The general prison population has an alarmingly high rate of risk factors for chronic disease [21]. Aboriginal people in particular are at higher risk of developing many chronic conditions due to higher rates of multiple risk factors compared with non-Aboriginal people. According to the 2009 NSW Inmate Health Survey, two-thirds of the Aboriginal women were overweight or obese and women were twice as likely as men to be physically inactive [11].

In total, 33 studies reported on substance misuse, with 22 studies reporting the extent of the issue [2, 3, 12, 16, 21, 25, 30, 31, 34, 36-46]. Substance misuse programs – including risky alcohol use, injecting drug use and polysubstance misuse – are key to the consideration of the health and wellbeing of Aboriginal people in custody and post release. Aboriginal people are more likely to be incarcerated if they have a history of substance misuse, and substance misuse is considered to be responsible for a large proportion of offending behaviour that leads to incarceration. Substance misuse also increased the risk of poor health, poor social and emotional wellbeing in prison and in the community, and risk of re-incarceration, hospitalisation and death after release.

There were 17 studies in our review that focused on mental health [4, 11, 20-24, 26, 27, 32, 33, 35, 38, 40, 47-49]. These studies indicated high levels of mental health problems among the general inmate population. The rates of mental health problems were even higher among Aboriginal people, women generally and Aboriginal women in particular [11]. None of
the 17 studies in the review that focused on mental health provided a definition of mental health. However, we noted that mental health problems were discussed in the literature in a way that suggests that mental illness is generally viewed as a disease. There was limited discussion of people’s social and emotional wellbeing and there was no mention of the stress of incarceration and the trauma that must be felt in response to incarceration.

Aboriginal people who had been in prison were found to be at a high risk of illness and injury post release. The main causes included mental and behavioural disorders and drug-related problems. In addition, former prisoners are at a significantly increased risk of death following release from custody, especially in the weeks immediately following release.

Social support needs

Aboriginal Australians released from prison are at risk of homelessness, frequent and unwanted moves and disruption. Lack of suitable housing, poor access to mental health services and family support are key factors in the unsuccessful transition to outside life for all inmates, with negative consequences for Aboriginal women in particular. The lack of secure and appropriate housing is connected to high levels of stress, difficulty advancing other aspects of life and places people at greater risk of repeat incarceration.

The effectiveness of throughcare programs in coordinating care from custody to the community

Throughcare is the main policy approach to post release work in Australia. The intention of this policy is to provide continuous management of prisoners’ needs from reception to release in order to support their successful reintegration into the community. A comprehensive definition of throughcare is provided in Appendix Two.

Corrective services and non-government organisations are the main providers of post release services [2]. However, access to corrective service programs depends on the nature of release. If a person has been in prison on remand or is released after serving a finite sentence (not on parole) then they are no longer considered a client of corrective services and have less access to formal post release programs in the community. This particularly disadvantages Aboriginal former inmates who are more likely to be incarcerated on remand. In addition, whilst prisoners released to freedom may be able to access services from community based organisations, these services are rarely coordinated by one agency and are not available to all prisoners prior to or on release [2].

The literature review reveals that in custody, pre and post release programs, including those linked with parole or with transitional programs like half-way houses, can reduce the risk of recidivism [2, 50-52]. In a US study, people recently released from custody identified structured drug and alcohol counselling and community based resources such as self-help groups as being protective against relapse to drug use [24]. Post release substance misuse programs can help prevent relapse to drug use and improve outcomes [53, 54], but they need to be of sufficient length and targeted to the needs of Aboriginal Australians and women if they are to be universally effective [55].

The article by Baldry and McClausland (2009) describes principles for effective support for Aboriginal women in transition and for some time post release, which include: throughcare; a holistic approach; healing; and services based on self-identified needs. These principles – especially throughcare and a holistic approach – appear relevant for all in custody, pre and post release intervention programs. Programs provided in custody and at release must be holistic, support immediate welfare needs and increase opportunities for improved longer term wellbeing, such as supporting housing, money, living skills and employment needs [50, 56, 57]. There is a need to consider the multiple dimensions of people’s circumstances and to focus on people’s capabilities, to build independence, facilitate self determination and support the development of social, employment and life skills [17].
The transition from custody to the community is a time of high vulnerability, during which the logistic problems related to re-establishment within a community are compounded by emotional distress, high medical and mental health needs, and risk of relapse to substance misuse and risky behaviours [23]. Therefore in custody, pre and post release support for Aboriginal people needs to be integrated and should incorporate social and mental health services in addition to substance misuse programs. The need for culturally appropriate drug and alcohol counselling and case management support to address issues such as housing, access to children and getting out of destructive relationships were identified as key needs in the pre and post release period in focus groups held with Aboriginal women in custody in Western Sydney [38].

Three types of coordinating care services were evident in the literature. These included the employment of a part-time Aboriginal worker as part of the WA office of custodial services [58]; discharge planning; and a community re-entry coordination program which refers inmates to agencies, accommodation, counselling and Centrelink.

For many Aboriginal people in custody, links with post release support within the community may need to be established and developed [12]. There was evidence that a simple referral to community based organisations and programs was useful in supporting reintegration into the community, but that linkages between in custody and community-based programs were lacking [59]. Further there was evidence of the need to maintain access to and communication with community based health services or health practitioners who were involved in the health care of an Aboriginal person prior to incarceration, in order to increase the effectiveness of in custody interventions [12]. For example, communication with health care providers who have managed clients with substance misuse problems prior to incarceration can inform what interventions in custody are more likely to be successful [2]. If Aboriginal community controlled health services or drug and alcohol services are available, they can also provide an important opportunity for care both in custody and after release [12, 29].

**Implications**

Whilst the need for health and social support interventions is high, Aboriginal people re-entering the community from prison face many barriers in accessing the services required to build lives in the community. Existing prison programs are rarely systematically available to all people in contact with prison, are rarely targeted to individual needs, culturally appropriate or connected to programs in the community. Few provide ongoing or continuous support. Many important programs have conditions that exclude those most in need for example those with a mental illness, cognitive disability or literacy problems and those on remand and short sentences.

Additional research is required to evaluate the impact of programs providing access to primary health care for Aboriginal people released from custody. More research is also required on the programs that specifically target Aboriginal people and the responsibility of corrective services, health services and non-government organisations in meeting their needs.

Further information on the physical, mental health and social support needs of Aboriginal people released from prison and the impact of post release programs on the coordination of care during the transition to the community can be found in the final report of the SPRINT systematic literature review on the APHCRI website.
PHASE 2: LINKED DATASET ANALYSIS

Aboriginal and non-Aboriginal Australians' patterns of morbidity and offenders' risk of hospitalisation in the five years post release from custody

Methods

The aims of this arm of the research were to better understand Aboriginal and non-Aboriginal offenders’ risk of hospitalisation andrehospitalisation in the five years post release from custody and to identify the common reasons for hospitalisations.

As part of her research, one of the chief investigators (EB) had developed a Mental Health Disorders and Cognitive Disability (MHDCD) dataset in the criminal justice system. This includes a cohort of 2,731 people (673 are Aboriginal) drawn from the 2001 NSW Inmate Health Survey and from the NSW Department of Corrective Services Disability Service Database, and links de-identified administrative records from Criminal Justice and Human Service agencies in NSW. These agencies include Corrective Services NSW, Juvenile Justice NSW, the NSW Police Force, Justice Health, the NSW Bureau of Crime Statistics and Research (BOCSAR), Legal Aid NSW, Community Services, Ageing Disability and Home Care, Housing NSW and NSW Health. Analysing information from the linked data set received ethics approval in 2006 from the Aboriginal Health and Medical Research Council (People with Mental Health Disorders and Cognitive Disability in the Criminal Justice System 569/06).

Linked data from Health and Corrective Services NSW was analysed to better understand Aboriginal and non-Aboriginal former inmates’ risk of hospitalisation andrehospitalisation over a five-year period from the 3rd April 2003 to the 3rd April 2008. The linked dataset was also analysed to identify the common reasons for hospitalisation.

The analysis identified patterns of morbidity and offenders’ risk of hospitalisation in the five years post release from custody, and in particular identified similarities and differences between Aboriginal and non-Aboriginal offenders. While the dataset contains admitted patient data for 1,899 patients, only 1,750 patients fitted our inclusion criteria (i.e. they were not in custody over the five-year period and had at least one hospitalisation).

Descriptive analysis was conducted on the frequency of reasons for hospitalisation. This was presented in graphic form for the three most common reasons for hospital admission.

We then analysed factors associated with admission. The independent variables we studied included age, sex, and whether or not the person was Aboriginal. Age was dichotomised into younger than or older than 35 years of age. We conducted univariate and multivariate analysis on the following dependent variables:

1. Number of admissions over 5 years after release (regression)
2. More than one admission (logistic regression)
3. Days between custody and first hospitalisation (poisson regression)
4. Days between first and second hospitalisation (poisson).

Results

To date research on the hospitalisation of former inmates has tended to focus on the immediate period after release from custody and the need for immediate transition support. In our research we examined a five-year period post release from custody because we wanted to understand the ongoing health needs and experiences of former inmates and to identify whether the experiences of Aboriginal former inmates were different to those of non-Aboriginal former inmates over the same time period. While access to immediate post release care for Aboriginal Australians – who are over-represented in prison and more likely to cycle in and out of prison on remand or by serving short sentences – is especially important, so too is what happens in the five years post release and the extent to which
institutions such as hospitals and mainstream primary health care services meet the specific needs of Aboriginal Australians.

The patterns of morbidity and hospitalisation in the five years post release from custody were quite similar for Aboriginal and non-Aboriginal offenders. However, differences exist between the classes of conditions and the frequency of readmission.

There were 957 people in the sample, 781 males (82.2%) and 170 females (17.8%), including 285 Aboriginal Australians (30.2%). The mean age was 35.2 years (St Dev 9.2 years).

**Reasons for hospitalisations**

The mean number of ICD-10 categories of reasons for hospitalisation was 4.98. There was no significant difference in the number by Aboriginality. However females reported more morbidities than males (mean 5.62 compared to 4.87, <0.01) and those more than 35 years reported more morbidities than those 35 years or younger (mean 5.57 compared to 4.60, p<0.001). This was confirmed by multivariable linear regression modelling.

The three most common categories of reasons for hospitalisation (principle and secondary) were mental and behavioural disorders, injuries and poisoning, and infectious or parasitic diseases. The frequencies of specific diagnosis in these categories are listed in Table 1.

**Table 1: Reasons for hospitalisation in three main categories**

<table>
<thead>
<tr>
<th></th>
<th>Non Aboriginal (n=685)</th>
<th>Aboriginal (n=285)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td><strong>%</strong></td>
<td><strong>N</strong></td>
</tr>
<tr>
<td><strong>Mental and Behavioural Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental and behavioural disorders due to psychoactive substance use</td>
<td>855</td>
<td>125%</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders</td>
<td>285</td>
<td>42%</td>
</tr>
<tr>
<td>Disorders of adult personality and behaviour</td>
<td>268</td>
<td>39%</td>
</tr>
<tr>
<td>Neurotic, stress-related and somatoform disorders</td>
<td>259</td>
<td>38%</td>
</tr>
<tr>
<td>Mood [affective] disorders</td>
<td>258</td>
<td>38%</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>104</td>
<td>15%</td>
</tr>
<tr>
<td>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence</td>
<td>84</td>
<td>12%</td>
</tr>
<tr>
<td>Organic, including symptomatic, mental disorders</td>
<td>76</td>
<td>11%</td>
</tr>
<tr>
<td>Disorders of psychological development</td>
<td>71</td>
<td>10%</td>
</tr>
<tr>
<td>Unspecified mental disorder</td>
<td>39</td>
<td>6%</td>
</tr>
<tr>
<td>Behavioural syndromes associated with physiological disturbances and physical factors</td>
<td>32</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Injury, poisoning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injuries to the head</td>
<td>367</td>
<td>54%</td>
</tr>
<tr>
<td>Poisoning by drugs, medicaments and biological substances</td>
<td>256</td>
<td>37%</td>
</tr>
<tr>
<td>Injuries to the wrist and hand</td>
<td>241</td>
<td>35%</td>
</tr>
<tr>
<td>Injuries to the elbow and forearm</td>
<td>152</td>
<td>22%</td>
</tr>
<tr>
<td>Injuries to the knee and lower leg</td>
<td>134</td>
<td>20%</td>
</tr>
<tr>
<td>Condition</td>
<td>Number (Aboriginal)</td>
<td>Percentage (Aboriginal)</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>---------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Injuries to the abdomen, lower back, lumbar spine and pelvis</td>
<td>127</td>
<td>19%</td>
</tr>
<tr>
<td>Injuries to the shoulder and upper arm</td>
<td>95</td>
<td>14%</td>
</tr>
<tr>
<td>Injuries to the thorax</td>
<td>95</td>
<td>14%</td>
</tr>
<tr>
<td>Injuries to the ankle and foot</td>
<td>77</td>
<td>11%</td>
</tr>
<tr>
<td>Complications of surgical and medical care, not elsewhere classified</td>
<td>76</td>
<td>11%</td>
</tr>
<tr>
<td>Injuries to the neck</td>
<td>67</td>
<td>10%</td>
</tr>
<tr>
<td>Toxic effects of substances chiefly non-medicinal as to source</td>
<td>61</td>
<td>9%</td>
</tr>
<tr>
<td>Sequelae of injuries, of poisoning and of other consequences of external causes</td>
<td>56</td>
<td>8%</td>
</tr>
<tr>
<td>Injuries to the hip and thigh</td>
<td>52</td>
<td>8%</td>
</tr>
<tr>
<td>Injuries to unspecified part of trunk, limb or body region</td>
<td>39</td>
<td>6%</td>
</tr>
<tr>
<td>Other and unspecified effects of external causes</td>
<td>27</td>
<td>4%</td>
</tr>
<tr>
<td>Burns and corrosions</td>
<td>23</td>
<td>3%</td>
</tr>
<tr>
<td>Effects of foreign body entering through natural orifice</td>
<td>18</td>
<td>3%</td>
</tr>
<tr>
<td>Certain early complications of trauma</td>
<td>17</td>
<td>2%</td>
</tr>
<tr>
<td>Injuries involving multiple body regions</td>
<td>10</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Infectious and Parasitic diseases**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number (Aboriginal)</th>
<th>Percentage (Aboriginal)</th>
<th>Number (Non-Aboriginal)</th>
<th>Percentage (Non-Aboriginal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial, viral and other infectious agents</td>
<td>188</td>
<td>27%</td>
<td>113</td>
<td>40%</td>
</tr>
<tr>
<td>Viral hepatitis</td>
<td>181</td>
<td>26%</td>
<td>66</td>
<td>23%</td>
</tr>
<tr>
<td>Other bacterial diseases</td>
<td>36</td>
<td>5%</td>
<td>26</td>
<td>9%</td>
</tr>
<tr>
<td>Intestinal infectious diseases</td>
<td>27</td>
<td>4%</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>Mycoses</td>
<td>24</td>
<td>3%</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>Other viral diseases</td>
<td>14</td>
<td>2%</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Viral infections characterised by skin and mucous membrane lesions</td>
<td>14</td>
<td>2%</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Human immunodeficiency virus [HIV] disease</td>
<td>5</td>
<td>1%</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Infections with a predominantly sexual mode of transmission</td>
<td>5</td>
<td>1%</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Pediculosis, acariasis and other infestations</td>
<td>4</td>
<td>1%</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Viral infections of the central nervous system</td>
<td>4</td>
<td>1%</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Other for example, helminthiases, tuberculosis</td>
<td>3</td>
<td>1%</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

* % = (number of hospitalisations*100)/ number of individuals in database.

Aboriginal former inmates had higher rates of infectious diseases for bacterial, viral and other infectious agents (40% versus 27%) than non-Aboriginal former inmates. These diseases should only infrequently require hospitalisation if they receive early and effective management.

Figure 1 shows the proportion of admissions for Aboriginal people that related to one or more of the three categories of diagnosis. Figure 2 shows the proportion of admissions for non-Aboriginal people that related to one or more of the three categories of diagnosis. The pattern was somewhat different for Aboriginal and non-Aboriginal offenders. More non-Aboriginal than Aboriginal admissions were for mental and behavioural disorders alone (22% vs 17%). By contrast more Aboriginal (9%) than non-Aboriginal admissions (2%) were for both injury/poisoning and infectious disease. This suggests that Aboriginal people are
more likely to have multiple classes of conditions, thus making their health care more complex to manage.

*Figure 1: Common reasons for admission for Aboriginal Australians who had been in custody*

*Figure 2: Common reasons for admission for non-Aboriginal Australians who had been in custody*
Frequency of hospitalisation

The mean number of hospitalisations was 1.98. There were no significant differences in the number of hospitalisations for Aboriginal or non-Aboriginal offenders, by age group or gender.

There were 593 people (55.2%) with only one hospitalisation and 482 (44.8%) with more than one (Table 2). Females, younger individuals and Aboriginal Australians were more likely to be admitted more than once.

Table 2: Number of hospitalisations

<table>
<thead>
<tr>
<th></th>
<th>One only</th>
<th>More than One</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>524 (57.1%)</td>
<td>394 (42.9%)</td>
<td>$X^2 = 8.8$ (0.003)</td>
</tr>
<tr>
<td>Female</td>
<td>69 (44.0%)</td>
<td>88 (56.1%)</td>
<td></td>
</tr>
<tr>
<td>Mean Age (SD)</td>
<td>34.9 (9.6)</td>
<td>33.1 (7.2)</td>
<td>t=3.47 p=0.001</td>
</tr>
<tr>
<td>Aboriginal Australians</td>
<td>167 (50%)</td>
<td>167 (50%)</td>
<td>$X^2 = 5.0$ (0.03)</td>
</tr>
<tr>
<td>Non-Aboriginal Australians</td>
<td>419 (57.6%)</td>
<td>309 (42.4%)</td>
<td></td>
</tr>
</tbody>
</table>

In multivariate logistic regression analysis the likelihood of admission more than once was not influenced by Aboriginality after adjusting for gender and age group (Table 3).

Table 3: Multivariate logistic regression analysis: factors associated with more than one hospitalisation

<table>
<thead>
<tr>
<th>Variable (Reference)</th>
<th>Odds Ratio</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Australians</td>
<td>0.79</td>
<td>NS</td>
</tr>
<tr>
<td>Male gender (Female)</td>
<td>1.59</td>
<td>0.009</td>
</tr>
<tr>
<td>Age group &gt;35 (&lt; = 35)</td>
<td>0.975</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Interval between custody and first hospitalisation

The mean interval between custody and first hospitalisation was 353 days. This was slightly longer for those over 35 years of age (382 days) compared with those 35 and under (334 days; p=0.02). There was no significant difference between Aboriginal and non-Aboriginal offenders or between male and female offenders. This was confirmed in generalised linear modelling adjusted for age group, sex and Aboriginality.

Interval between hospitalisation and rehospitalisation

The mean interval between first and second hospitalisation was 239 days. For Aboriginal former offenders the mean was 187 days compared to 259 days for non-Aboriginal former offenders (t=2.90, p=0.004). There was no significant difference for males and females, however older offenders had a longer interval (t=3.5, p<0.001). Aboriginality remained significant after adjustment for age and sex in regression analysis (Table 4).

Table 4: Generalised linear modelling: factors associated with the number of days between first and second hospitalisation

<table>
<thead>
<tr>
<th>Variable (Reference)</th>
<th>Beta coefficient (St Error)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Australians</td>
<td>-0.30 (0.13)</td>
<td>0.03</td>
</tr>
<tr>
<td>Male gender (Female)</td>
<td>0.18 (0.13)</td>
<td>NS</td>
</tr>
</tbody>
</table>
Implications

We found that Aboriginal former inmates are more likely to suffer from multiple classes of disease and therefore have more complex health issues to manage; and are more likely to have a shorter interval between the first and second admission to hospital. The finding of more complex health issues among Aboriginal former inmates suggests that even though Aboriginal former inmates are not presenting initially to hospitals more frequently than non-Aboriginal former inmates, they are presenting with more complex problems. This suggests a need for greater coordination of care in the immediate aftermath post release to ensure that these complex health needs are identified and managed more comprehensively.

The shorter interval between hospital admission and readmission for Aboriginal former offenders may indicate a failure of hospital follow-up care and also presents an opportunity for primary health care to do more to actively support Aboriginal ex-offenders discharged from hospital who may be vulnerable to discontinuity of care. If patients are not adequately followed up and managed by primary health care providers then their conditions are unlikely to be adequately controlled, resulting in readmission to hospital. Again more active follow-up and communication post discharge from hospital is required both with patients and their primary care provider to ensure that the provider is aware of the patient’s health status and is able to make a plan for the patient’s follow-up and ongoing care. If patients do not regularly see a provider, this needs to be suggested and arranged.

The findings point to a failure of connection between hospital and the community, as well as between custody and the community, that particularly disadvantages Aboriginal former inmates compared with non-Aboriginal former inmates in the five years post release. Currently some Aboriginal people released into the community access post release services and primary health care and successfully reintegrate into the community. However, large numbers of Aboriginal people cycle back in and out of prison on short sentences or remand [11, 12] or cycle in and out of hospital. This may be part of a lifetime of institutional recycling fuelled by exclusion from continuity of care in schools, prisons, hospitals or other mainstream institutions. Whilst this exclusion may not be intentional, it is a consequence of failing to understand and address the particular circumstances and needs of Aboriginal Australians. Therefore we may need to take a longer-term view when supporting Aboriginal people released from custody, and establish better systems for dealing with the complexity of the problems they face that disrupt reintegration in the community post release.

PHASE 3: QUALITATIVE INTERVIEWS

The factors influencing access to primary health care services post release from prison

Methods

The findings of the systematic literature review were used to inform the development of an interview guide for qualitative analysis. For example the literature review revealed that a great deal more is known about the health and social support needs of Aboriginal people in custody than is known about the needs and experiences of their family members, or about inmates’ access to and the effectiveness of post release programs for Aboriginal people on release. It was therefore considered important to interview family members as well as Aboriginal former inmates and community service providers.

Three interview guides (one for Aboriginal former inmates, one for family members and one for service providers) were developed by a team of health professionals at the Aboriginal
Medical Service Western Sydney (AMSWS). The draft interview guides were circulated to the chief investigators (CIs) for input and comments.

The qualitative phase of the study was approved by the University of New South Wales Human Research Ethics Committee (HC12480), the Aboriginal Health and Medical Research Council (AH&MRC) (874/12) and the Justice Health and Forensic Mental Health Network Human Research Ethics Committee (G388/12).

Purposive sampling was used to identify interviewees who were Aboriginal and had either been in contact with the criminal justice system or had a family member who had been in prison. Care was taken to ensure perspectives were sought from men and women over the age of 18.

Twenty nine interviews were conducted by the team of health professionals from the AMSWS between September 2012 and February 2013. Of these, 12 were interviews with Aboriginal people who had been in prison; nine were with family members and eight with community service providers.

Family members were asked what life was like for them and their family with a relative in prison. They were also asked about their relative’s access to health while leaving prison and on release, and the kinds of health services and support that would be most helpful to Aboriginal former inmates and their families on release from prison. Community service providers were asked about how they work with Aboriginal people leaving custody, the factors that assist them in providing effective services and the factors that impede them from performing the work that they would like to do. They were also asked about other service providers they work with and their perspective on what is important to Aboriginal people leaving prison.

We focused the interview questions on former prisoners’ access to services during the transition from prison to the community, rather than focusing on their diseases or medical conditions.

Interviews were digitally recorded and transcribed verbatim. The text was then organised under major headings. The in-depth interviews were analysed thematically in each of their separate groups by JL and KMB with advice and input from EB. Cross cutting themes across the three groups were then identified. These common themes were discussed with the team at AMSWS and it was agreed to interpret the findings in light of the throughcare policy of Corrective Services NSW and within a human rights framework.

The findings from the qualitative arm of the research were presented at the Correctional Services Healthcare Summit, Melbourne, on 29-30 August 2013. The findings were fed back to AMSWS staff and community members at a workshop in Mount Druitt on 4 September 2013, and to community members at a workshop at the Aboriginal and Islander Health Worker Journal at Little Bay on 8 October 2013. A graphic facilitator was used to track the discussion and to keep a record of the workshop at AMSWS; his notes and illustrations can be found in Appendix Three. These notes were not used to inform the findings of the research; rather the workshops were conducted to ensure that there was feedback to the team at AMSWS and to Aboriginal community members. The discussion at the workshops helped to refine and prioritise the recommendations stemming from the research.

Results

The qualitative interviews with Aboriginal people who had been in prison, family members and community service providers provided insight into the barriers to and support available for Aboriginal people accessing community primary health care after release from custody.

The major factors influencing access to primary health care post release from prison depends largely on family involvement in post release care and support and the extent to which throughcare services were provided to Aboriginal people in custody. Each of these themes is discussed in turn.
Family involvement

The interviews with Aboriginal former inmates and family members of inmates revealed the important role that family members play in providing support to their relatives while they are in prison and on release. Family members included siblings, parents, aunts, partners or children of former inmates. Where the family member was an aunt (n=2), a sister (n=2), or mother (n=2), they were more aware of the services their relative needed and had accessed. Children (n=1) and partners (n=2) were less able to provide information about the services their relative had accessed in custody and on release.

The majority of family members interviewed were women. In most cases these women were the main and sometimes only support for the former inmate. Often relationships with other family members were fractured, so the responsibility of support fell primarily to one or two people within the family.

Two of the family members of former inmates interviewed were supporting more than one relative in prison. One was a sister who had two siblings in prison with mental health problems; the other was a mother who had two sons in prison on short sentences. The sister – aged in her early thirties – supports her brother to attend rehabilitation and to continue visiting the Aboriginal Medical Service. Whilst her other sibling – a sister – is in transition from the criminal justice system and is being looked after in a half-way house, she still tries to care for her and provides practical assistance such as helping her find furniture and household items. In this family member’s experience, having a strong advocate for former inmates during transition from custody is extremely important.

All family members interviewed found having a family member in prison stressful and traumatic. The trauma and stress of release appeared to impact differently on family members depending on a number of factors such as the family circumstances and the dynamic of the family group; the level of support required and whether or not the family member needed to be accommodated; and the ability of family members to navigate government agencies and post release services available to the former inmate. A former inmate’s mental health and level of substance misuse also have a significant impact on family members’ ability to cope and support the former inmate’s transition post release.

One of the family members interviewed was the sister of a former inmate and expressed fear for her welfare and for that of her mother when he is living with them. Her brother – who is 35 years old and has been using marijuana since he was 11 – has been in and out of custody for years, with the longest term around six to eight months. Her brother suffers from paranoid schizophrenia, which was diagnosed when he was about 20 and which is exacerbated with drug use. The sister describes feeling relief when her brother is incarcerated, mainly for the sake of her mother and because she feels that his mental illness is being managed in custody. She notes that when he is released, he is clear and drug-free, but within a week or two he is using drugs again and becomes quite aggressive. She says that the rest of the family have ‘wiped their hands of him’ and that therefore it is left to the sister, who mostly supports her mum, and the mother, who supports her son. The sister is frightened that her brother will harm her mother one day.

I’m scared he’s going to really hurt her one day. And he’s quite capable. He’s hurt other people, even women, by punching them in the face, and that was a cousin who allowed him to stay there. He had nowhere else to go, so he’s quite capable of harming mum when he gets into one of his ... [When he is released] I get a bit anxious. So does mum ... I don’t get anxious for me; I get anxious for my mother, because at the end of the day she wears the brunt of everything. (Family member – sister)

The majority of family members indicated that they were not involved in decisions affecting inmates’ health care, but felt that their involvement could support their relatives’ healing, support the continuity of care from custody to the community, and could reduce anxiety. However family members recognised that there are limits to what they are able to do to
support family members who had been in custody. For example a mother commented that she tried to encourage her son to access services, but he would not listen. An aunty also stated that there were certain cultural and gender issues that were not appropriate for her, as a woman, to deal with when supporting her nephew.

Throughcare
The qualitative analysis revealed that effective access to primary health care on release and during transition is positively influenced by appropriate health care in custody and planning for release while in custody. Seamless health care for people in contact with prison is necessary if former inmates are to access appropriate primary health care in the community. There are three stages that influence this, and each stage requires a different approach.

> **In-custody** there is a need to address health issues such as mental illness, chronic disease, multi morbidities and day-to-day illnesses.

> **Pre-release** there is a need to build communication between health care providers in custody and in the community, and there is a need to ensure that social support services are accessed such as Centrelink and Housing because access to income and housing impacts on peoples’ social and emotional well being and practically on their ability and time to attend a primary health care service.

> **Post-release** there is a need to access primary health care in the community.

**In-custody**
According to the findings of the literature review health issues particularly affecting Aboriginal inmates include mental illness, chronic disease, and substance misuse and multi morbidities. However the management of mental health and exposure to the trauma of incarceration were of primary concern to the participants interviewed.

The majority of participants reported that mental health care in custody tended to focus on medications rather than supporting other interventions. Some family members described feeling relief once their relative was incarcerated because they knew that at least their family member was taking their medication. Others felt that the mental health care in custody was inadequate:

They’re just in there to do their time, and get medicated and keep the calm and out of their hair. More or less, but they don’t get much more help than that. (Family Member – sister)

Community service providers also supported the finding of a reliance in custody on mental health medications. Some community service providers felt that the culture of mental health service provision in custody is different to the culture of service provision in the community:

[in the community] we do motivational interviewing to help reframe their life, to give them positive feedback... about their own capabilities. (Mental Health Service Provider)

In addition, Correctional Service’s policy of ‘suicide-watch’ was considered by participants as traumatic and seen as a barrier to seeking appropriate mental health care in custody. Instead of being provided with access to mental health services, one inmate was exposed to additional trauma when incarcerated, by being put on a suicide-watch. The inmate felt isolated and dehumanised by being stripped of clothing and cigarettes and the right to visits:

... they put me on a RIT, a suicide-watch. That just stressed things even worse. I was in a cell for 23 and a half hours a day. You only get a half an hour release ... Yeah and I had no clothes. I was in my jocks. No smokes. No one to talk to. (Aboriginal man, late 30s, former inmate)

In terms of suicide, the priority for Corrective Services appears to be ensuring that inmates do not harm themselves, as opposed to ensuring that inmates have access to services or
considering their wellbeing. This inmate was on remand for four months and was put on suicide-watch for two weeks. He was not provided with any ongoing counselling or support, but was instead returned directly to the main prison. The fear of being put on suicide-watch if an inmate displays suicidal tendencies is likely to diminish their trust in health care providers. A learned behaviour of inmates coming out of prison might therefore be to conceal trauma, which may in turn reduce the ability of primary health care providers to provide them with effective mental health care in the community.

Two main barriers to accessing health services in-custody – and therefore to effective pre-release and discharge planning – were identified through the qualitative arm of the research. Firstly the structural constraints of Corrective Services acted as a barrier to inmates accessing health services. These constraints included factors such as placing people in prison on short sentences and on remand which mean that the inmates lives were disrupted; they may have lost their house and possessions, but they did not have, or know if they would have, sufficient time to access the services available in prison. Secondly some participants viewed the paucity of culturally appropriate and targeted health services in custody as a barrier to accessing in custody health services. For example, some participants criticised in custody health services as being too clinical and not involving family members. Culturally appropriate health care services would therefore provide better access to comprehensive and effective health care for Aboriginal Australians in custody.

Pre-release

Participants’ response indicated that discharge planning and communication was variable and was hampered by uncertainty regarding release dates and the lack of access to Medicare. The extent to which communication occurs between prison and community services appeared to depend on whether a person is released to freedom or on parole, or is sentenced or on remand, and also on the length of the imprisonment. Aboriginal former inmates who were in prison for short periods on remand were far less likely to experience good linkages between prison and community services.

Service providers and former inmates indicated that uncertainty regarding release dates meant that discharge summaries were not always written and a week’s supply of medication not always provided to inmates on release. This contributes to a lack of continuity of care and places additional pressure on inmates and family members to identify their immediate needs and establish their own links with community services.

The majority of service providers indicated that there is a strong need for pre release planning for all inmates, regardless of the nature of their incarceration (e.g. remand or sentenced). There is a need to connect inmates with community services prior to their release so that they are able to access available services and support.

“… near the end of that term [of imprisonment] that’s when there should be some real serious work done with that client with regards to setting up the supports ready to go out. So places like Housing should be contacted. The medical centre should be contacted. If they need furniture and stuff, all those things should be ready so that when people get out of jail, they’re not just left and then they’ve got to struggle to re-establish everything again. (Service provider – Housing NSW)

Another service provider suggested that there is a need for coordinated and holistic pre release planning across all services:

“I think what needs to happen, everyone needs to sit down and say, alright, well, this is what’s going to go on [before release]. This is the plan … By a strong team, I’m talking about you have someone from Probation and Parole. You have somebody from the HASI program … You have somebody from mental health. You have somebody from drug and alcohol. They don’t have
to be from the same service, but they have to know what role they’re actually planning. (Service Provider - Aboriginal mental health worker)

Post-release

Being released from custody is a time of high emotional stress for former inmates and their families. It is especially important to support people’s access to health care during this period. Family members felt unsupported while trying to help former inmates adjust to community life and deal with drug use, aggression or mental health issues.

One service provider emphasised that in order to be effective, post release support must be immediate and easily accessible upon release.

When they first get released make sure you’re in their face. Don’t say come and see me in a week’s time. Actually get there, see the patient, and say, ‘Hey look this is what you need to do.’ Keep them busy for that week... I think the critical time is the first three months. (Service provider - Aboriginal mental health worker).

The majority of participants reported that there were inadequate links to community services from prison. The lack of discharge continuity places pressure on service providers who have to make assessments without important information regarding diagnoses made and treatments provided in prison.

Justice Health can help me enormously if I’m making an assessment by providing a good quality discharge summary and the reasoning why a diagnosis has been made in jail. (Community service provider – mental health).

Some service providers commented that whilst good programs are available for Aboriginal people who have been in custody, Aboriginal former inmates are not aware of these services. In addition to the lack of awareness of services there is also a sense that former inmates do not always meet the criteria needed to access the services, which means that people are turned away if they do not meet the criteria.

It is very hard to get into rehab centres. There was one family, almost got them in ... And then one of them was still on methadone, and they don’t accept the methadone. A person has to be completely off the methadone and that’s really hard. Yes so then that family couldn’t go there. They couldn’t get the assessment to go there, so they were going to go up to Longhaven, but they just kind of lose that enthusiasm once they’re put off and told to go somewhere else. (Community service provider – family worker)

Another interview highlighted the importance of services having an ‘open door’ policy:

We need to have people with pathways, even if they’ve [got] stuck for many years in destructive pathways; we need to keep opening doors. I don’t know where I heard the term recently, but no wrong door, and I think that’s a good – we’ve got to get away from the idea of ‘Oh you don’t belong in our category of people we help, go away’. (Community service provider, mental health)

Better access to health care in the community was reported by those who had been in custody on a sentence longer than six months, and by those who felt empowered – usually through family support or a good case worker – to receive the care that they need.

Emotional (listening), informational (advice) and instrumental (finances, housing, furniture) supports assisted people to access services in the community. The majority of former inmates indicated that housing, transport, employment and social inclusion were all significant issues on release. Many of the former inmates who had trouble adapting back to community life found it difficult to feel safe and to find a place where they felt they belonged. Having stable housing was considered an important part of feeling safe.
We found that there was inadequate continuity of comprehensive health care in the context of complex needs and significant emotional distress and anxiety, partly because there is no single agency solely responsible for the post release needs of Aboriginal people released from custody.

**Implications**

The qualitative analysis found that there are some significant barriers to ensuring effective and appropriate health care for Aboriginal people in custody and on release:

- The structure and processes of Corrective Services such as placing people in custody on remand or short sentences acts as a major barrier to Aboriginal people accessing primary health care services in custody and on release, because they are less likely to have received comprehensive health care in custody and to have received transitional planning.

- The paucity of culturally appropriate health services in custody is also a barrier to accessing in custody health services. In turn, this contributes to poor discharge planning and poor access to health care post release. When we presented the findings to the Aboriginal Medical Service and the community workshop, some of the participants’ comments regarding the trauma caused by incarceration can be compounded by not being able to attend family funerals and not being able to celebrate cultural events such as NAIDOC week. This suggests the existence of culturally appropriate health services, and access to cultural events such as NAIDOC week and establishing opportunities for cultural connection and discussion while in custody are important to Aboriginal inmates’ health and wellbeing.

- While not mentioned in the qualitative interviews, the suspension of access to Medicare for all prisoners, even if they are on remand, was raised as an issue in the feedback workshops to the Aboriginal Medical Services and to community members. The inability to access Medicare was considered a breach of human rights (especially for inmates on remand) and as a major barrier for community health service providers to provide in-reach services. The inability to access Medicare also hinders outreach services. For example prisoners cannot attend an Aboriginal Community Controlled Health Services while they are in custody.

Some former inmates reported accessing health services in custody and receiving transitional care. This was more likely if former inmates were sentenced for longer periods and if they had access to good case managers post release. Family members can also act as important brokers to accessing primary health care services in the community. Indeed, family support appears to be the greatest predictor of successful reintegration into the community.

Even though throughcare is the official policy of Corrective Services, these findings suggest that it is not always realised in practice for all inmates. This is especially the case for Aboriginal Australians who are more likely to be incarcerated on remand or to cycle in and out of prison on short sentences and to be disadvantaged by not accessing culturally appropriate health care in custody. The lack of throughcare limits access to primary health care services on release and during transition and leaves former inmates – and family members – feeling unsupported, thus increasing the risk of reincarceration.

Transitional support is therefore urgently needed for Aboriginal people released from custody. In order to be effective, this support needs to be immediate and systematically available to all regardless of remand status, the length of incarceration or the nature of release. It also needs to include access to emotional, information and instrumental support and be comprehensive, involve family members where possible and continue for at least six months. Comprehensive services should be able to deal with complex multimorbidities such as mental illness, drug and alcohol misuse and chronic disease, and consider a person
within their socio-cultural context. The socio-cultural context might include family, access to community and culture, housing, income and employment.

Finally, to provide comprehensive and coordinated care, either the duty of care of Corrective Services needs to be expanded to cover a transition program or community agencies need to be supported to provide in-reach services and facilitate discharge planning.

Discussion

The SPRINT project aimed to identify how primary health care services can better meet the health care and social support needs of Aboriginal Australians released from the criminal justice system. A systematic literature review, a linked data set analysis and qualitative interviews with former inmates, family members and community service providers were conducted.

We found that the health and social support needs of Aboriginal inmates released from custody are high and that it is especially important to target Aboriginal people for support post release. Aboriginal Australians are over-represented in prison and face additional disadvantage because of the nature of their offending and incarceration. The evidence also suggests that Aboriginal people in particular are more likely to be excluded from mainstream post release services.

While throughcare is the main policy approach to post release care in Australia, we found that it is not realised in practice and that there are numerous structural barriers to implementing throughcare for Aboriginal inmates in particular. The SPRINT project revealed that more must be done to overcome the barriers to implementing throughcare for Aboriginal people and that primary health care has an important role to play in supporting Aboriginal people released from custody.

POST RELEASE NEEDS OF ABORIGINAL FORMER INMATES

During transition from custody to the community, Aboriginal former inmates experience high vulnerability, trauma and emotional distress, have higher medical and mental health needs, higher risk of illness and injury, and increased risk of relapse to substance misuse and risky behaviours post release. Reconnecting with family, community and culture are key needs for Aboriginal people post release.

In the five years post release we found that Aboriginal former inmates are also more likely to suffer from more than one class of disease, for example mental illness and infectious diseases and therefore have more complex health issues to manage post release mostly resulting in shorter intervals between the first and second admission to hospital. While access to post release care for Aboriginal Australians – who are over-represented in prison and more likely to cycle in and out of custody on remand or by serving shorter sentences – is especially important, so too is what happens in the five years post release and the extent to which institutions such as hospitals and mainstream primary health care services meet the specific needs of Aboriginal Australians.

Why supporting Aboriginal people post release, rather than just supporting former inmates generally, is particularly important

The fact that Aboriginal people are over-represented in prison, with high rates of recidivism is well known [1, 60]. The nature of incarceration also tends to be different for Aboriginal people than non-Aboriginal Australians. Aboriginal people are more likely than non-Aboriginal Australians to serve shorter sentences, to be placed on remand as opposed to being released on bail, and to cycle in and out of prison from a young age. Therefore in
addition to high incarceration rates, the nature of incarceration tends to further disadvantage Aboriginal Australians [41].

Appropriate and effective post release support has the potential to disrupt the cycle of disadvantage experienced by Aboriginal people in contact with the criminal justice system. However higher recidivism rates among Aboriginal Australians suggests that mainstream post release services are not meeting the needs of Aboriginal former inmates and are missing opportunities to do more to break the cycle of recidivism. Aboriginal former inmates who are more likely to miss out are those who are released to freedom, those who were in custody on remand rather than sentenced, those imprisoned in remote areas and Aboriginal women.

Further the findings from the linked data set suggest that the difficulties that Aboriginal people face in accessing health and social support services when released from custody can continue indefinitely and create further institutional recycling (such as with hospitals) and poor access to effective health care in the five-year period post release. Exclusion from – or failing to access – mainstream post release services may be part of a lifetime of institutional recycling experienced by many Aboriginal Australians. This institutional recycling may be fuelled by exclusion from continuity of care in schools, prisons, health care, hospitals or other mainstream institutions.

The marginalisation that many Aboriginal people in contact with the criminal justice system face is likely to have a cumulative and continuing impact. Aboriginal people are at increased risk of poor schooling and unemployment, social exclusion, poor physical and mental health, drug and alcohol issues, unstable housing and an unsupported childhood. These risk factors are well established pathways into prison. Our findings suggest that Aboriginal people released from prison face many barriers to accessing essential services such as housing and health care, and that these barriers to accessing services can continue indefinitely and apply to accessing hospital services in the five year period post release from custody. While not the case for all Aboriginal people, the findings suggest that in general mainstream institutions do not necessarily provide adequate access to high quality services for Aboriginal Australians and that these barriers act to further marginalise some Aboriginal Australians from mainstream society.

THROUGHCARE FOR ABORIGINAL AUSTRALIANS

Throughcare is intended to provide continuous management of prisoners’ needs from reception to release in order to support their successful reintegration into the community. Principles for appropriate and effective throughcare for Aboriginal inmates include programs that are: holistic, comprehensive (incorporating health, social support, housing, and other needs), culturally appropriate and targeted to the needs of Aboriginal inmates, continuous during transition from custody to the community and immediately available and of sufficient duration to support former inmate’s needs over a long period of time.

Structural barriers to implementing throughcare for Aboriginal inmates

While throughcare is the main policy approach, we found that there was inadequate continuity of comprehensive health care in the context of Aboriginal inmates’ complex needs and significant emotional distress and anxiety. Essential components of throughcare are commonly absent from in custody, pre and post release programs for Aboriginal people. Structural barriers to Aboriginal prisoners accessing appropriate health care from reception to post release include: patterns of incarceration and release conditions; no mandate or requirement for health services in custody to be culturally informed or appropriate; workforce shortages – in particular inadequate numbers of qualified Aboriginal health practitioners and those specialising in mental health; funding constraints brought about by the suspension of Medicare; poor linkages, communication and discharge planning between prisons and
community health services; no clear duty bearers or agencies responsible for supporting the transition from prisons to the community; and a lack of accountability requirements to facilitate evaluations on release programs for former inmates. Each of these structural barriers is discussed in turn.

Patterns of incarceration and release conditions

Patterns of incarceration for Aboriginal people include high rates of remand and short sentences and these present a structural barrier to Aboriginal people accessing supports in custody, pre and post release. For example, placing Aboriginal people in prison on short sentences and on remand means that whilst in custody, inmates’ lives are disrupted; they may lose their house and possessions, but they do not have, or know if they will have, sufficient time to access the services available in prison. We also found that Aboriginal people who were in prison for short periods on remand were far less likely to experience good linkages between prison and community services.

The extent to which communication between custody and community occurs appeared to depend on whether a person is released to freedom or on parole, is sentenced or on remand, and also on the length of the imprisonment. In the qualitative interviews, better access to health care in the community was reported by Aboriginal former inmates who had been in custody for longer than six months, and by those who felt empowered, usually through family support or a good case worker, to receive the care that they need.

No mandate or requirement for health services in custody to be culturally appropriate

The paucity of culturally appropriate and targeted health services for Aboriginal people in custody was seen as a barrier to accessing in-custody health services. Our qualitative interviews revealed that some Aboriginal former inmates view in custody health services as being too clinical and not involving family members and are therefore not culturally appropriate. There appears to be no requirement for health services in custody to be culturally informed or appropriate.

Workforce limitations – in particular inadequate numbers of qualified Aboriginal mental health practitioners

The literature review and qualitative interviews revealed that there are inadequate numbers of Aboriginal health and mental health staff to ensure holistic and quality mental health care in custody and to ensure continuity of mental health care from custody to the community. This is particularly relevant for Aboriginal inmates and former inmates, due to the higher rates of mental illness among Aboriginal people in custody compared with non-Aboriginal people and the need for culturally appropriate mental health care.

Funding constraints brought about by the suspension of Medicare

The suspension of access to Medicare for all prisoners, even if they are on remand, acts as a barrier for community health service providers to provide in-reach services to Aboriginal inmates. It also prevents outreach services. This means that Aboriginal prisoners, in particular, are not able to access culturally appropriate services in custody. For example prisoners cannot choose to attend an Aboriginal Community Controlled Health Services while they are in custody.

Poor linkages, communication and planning between prisons and community health services

There is a lack of intersectoral collaboration between prisons and community health services, which means that upon release Aboriginal Australians – and Aboriginal women in particular – are left wanting for care that is respectful, planned, coordinated and realistic. The literature and Aboriginal participants’ responses indicated that discharge planning and
communication with community services and family members was variable and hampered by uncertainty regarding release dates and the lack of access to Medicare.

Uncertainty regarding release dates for Aboriginal inmates meant that discharge summaries are not always written and a week’s supply of medication is not always provided to inmates on release. This contributes to a lack of continuity of care and places additional pressure on inmates and family members to identify their immediate needs and establish their own links with community services. The lack of discharge continuity also places pressure on service providers who have to make assessments without important information regarding diagnoses made and treatments provided to Aboriginal people whilst in prison.

No clear duty bearers or agencies responsible for supporting the transition from prisons to the community

The Human Rights Framework describes the important role of duty bearers in upholding human rights for Aboriginal prisoners. However, both the literature review and the qualitative interviews revealed that one of the major barriers to developing and evaluating transition programs for former inmates is that there is no single agency responsible for supporting transition. Whilst Corrective Services are responsible for providing social, education and other services to people in custody and Justice Health is responsible for health care, there is no similar agency responsible for providing similar programs to people released from the criminal justice system – particularly those released to freedom, rather than released on parole [2].

In particular, despite the significant over-representation of Aboriginal people in the criminal justice system and the much higher rates of recidivism among Aboriginal former inmates, there is no agency with responsibility for supporting Aboriginal people during transition. At a minimum, Aboriginal people released to freedom will need to access Centrelink for continuing financial assistance, a shelter for emergency accommodation, the housing department for assistance with accommodation and a health service for their health care needs.

Therefore either the duty of care of Corrective Services or Justice Health needs to be expanded to cover a transition program, or community agencies need to be established to support people in custody and to facilitate discharge planning. The lack of known duty bearers makes it difficult to build the capacity of service providers and hold governments accountable to their obligations.

Lack of evaluations on release programs for Aboriginal former inmates

The literature review revealed that there is little research evaluating the impact of programs providing access to primary health care for Aboriginal people released from custody. Even less research was available on the programs that specifically target Aboriginal people and the responsibility of Corrective Services, Justice Health and non-government organisations in meeting their needs. This suggests that there is a lack of accountability requirements (and therefore expectations) that encourage the evaluation of the effectiveness of post release programs for Aboriginal former inmates.

Strategies for delivering effective throughcare

In order for these barriers to be overcome and for throughcare to be achieved for Aboriginal inmates, health care services need to be accessed continuously and in particular at four stages: in custody, pre release, during transition, and post release. Each stage requires a different approach.

In-custody

The findings from the literature review suggest that Aboriginal people are more likely to access health care while they are in prison than when they are in the community [21, 61], however access remains limited by the lack of culturally appropriate health services and the
patterns of incarceration, which include high rates of remand and short sentences [62]. It is a sad indictment on Australia’s health care system if the best access to health care that we can provide to disadvantaged Aboriginal Australians is while they are imprisoned from family and community. Universal access to health care is one of the core values underpinning the Australian health care system, including but not limited to Medicare.

We found that health services in custody need to appropriately address health issues particularly affecting Aboriginal inmates such as mental illness, chronic disease, multi-morbidities and day-to-day illness. The qualitative analysis highlighted the need for a more holistic approach to mental health care for Aboriginal Australians. In particular, revisions of the policy of ‘suicide-watch’ policy are necessary to reduce unnecessary trauma while still protecting those at risk of suicide. Rather than an over-reliance on medications, additional behavioural interventions are important as is the need to involve family members in mental health care. The trauma caused by incarceration can be compounded by not being able to attend family funerals and not being able to celebrate cultural events such as NAIDOC Week with the community. Further there is a need to increase access to culturally appropriate health care through the employment of Aboriginal health practitioners with expertise in mental health. These findings are supported by Rule 80 of the UN Standard Minimum Rules for the Treatment of Prisoners which states from the beginning of a prisoner’s sentence ‘consideration shall be given to his future after release and he shall be encouraged and assisted to maintain or establish such relations with persons or agencies outside the institution as may promote the best interest of his family and his own social rehabilitation’.

While a number of Aboriginal Community Controlled Health Services provide in-reach services to people in custody, these have not been adequately evaluated or supported to date and these services are not widespread or universally available. For example, in NSW an Aboriginal Chronic Care Program, funded by NSW Health, has been operating for a number of years in 50% of the prisons. While this program offers an important example of the benefits of running targeted programs for Aboriginal Australians in custody, more needs to be done to support broader access to the program for all Aboriginal people in custody and to provide more holistic care (not just chronic disease but also address mental health and other conditions and address social support needs) and also to ensure that the program is adequately resourced and evaluated, and that the evaluation findings are used to further improve the program.

The implementation and sustainability of programs targeted at Aboriginal people in custody is hampered by inadequate access to long term and adequate funding and the inability to use Medicare to charge for essential release planning services or preventive care strategies such as the Adult Health Check.

While access to education programs in custody was not a major theme in the qualitative interviews, the systematic literature review did demonstrate that access to education in custody is an important part of holistic care, providing an opportunity for self development and rehabilitation.

Pre release

Seamless care between custody and the community requires pre-release planning and effective communication between in-prison health services and community health care services and providers. Prior to release from custody there is a need for in custody health service providers to communicate with health care providers in the community. It is also important to ensure that social support services are accessed prior to release such as Centrelink and Housing. The qualitative interviews revealed that without coordinating health care from custody to the community for Aboriginal former inmates, the responsibility for accessing primary health care falls to the former inmates themselves or their family members.
Findings from the literature review and the qualitative interviews suggest that linkages between in custody health services and community health services could be improved. In particular, inmates were not always supplied with medications on release or provided with a discharge summary or referral to a community health service. Without such essential information former inmates are unlikely to receive continuity of health care.

According to the Australian Institute of Health and Welfare’s (AIHW) Health of Australia’s Prisoner’s Report 2012, 72% of sentenced prisoners with a planned exit had a health-related discharge summary in place at the time of their release. This statistic is based on a 2-week data collection conducted by the National Prisoner Health Data Collection (NPHDC). Only 26% of remand prisoners who were released had a discharge summary on file, and only 34% of sentenced prisoners whose exit was not planned had a discharge summary on file. This data excluded WA because they did not participate in the 2012 NPHDC [14].

As part of the NPHDC data collection process, prisons indicated that in general the process for health-related discharge planning ought to include the following steps:

> Before release, each prisoner is seen at the prison clinic.
> A discharge summary and letter for the prisoner’s GP is prepared and either given to the prisoner or forwarded to the prisoner’s GP or community clinic.
> The discharge includes information on the prisoner’s medical history, current problems, allergies, special diets or other needs, scheduled future appointments, recent test results, current medication, vaccination record and clinic contact details.
> If required the prisoner is referred to appropriate community services such as the GP or community health clinic, accommodation support or mental health service.
> The prison clinic will coordinate referrals and make appointments required for specialist consultations or hospital appointments such as methadone programs.
> Many prison clinics will also provide a limited supply of ongoing medication (i.e. 1-2 weeks) or arrange for these to be collected from a pharmacy.

This suggests that at best, discharge planning for former inmates only occurs prior to release rather than on admission as recommended by throughcare policy. Discharge planning is more likely to occur among inmates where a release date is known, as opposed to applying to all prisoners irrespective of their conditions of release, and former inmates are not necessarily referred to appropriate community services. It is not clear under what circumstances a community referral is deemed appropriate and necessary. Not all prison clinics supply ongoing medications and, of those that do, this is only possible for those inmates who they know are being released. The findings in the AIHW report reveals that further work is needed to support prison clinics to undertake universal and comprehensive discharge planning. Some of this support could be provided through primary health care services with the appropriate level of resourcing and infrastructure.

Effective communication between prison health clinics and community based health services is needed throughout a person’s incarceration, but in particular on reception and immediately prior to release from custody. It would be helpful if practitioners who were involved in the health care of Aboriginal prisoners prior to incarceration could inform prison health clinics about the patient’s health care needs and in turn for health clinics to gain consent from Aboriginal prisoners to make contact with practitioners to seek the required health information. For example, communication with health care providers who have managed clients with substance misuse problems prior to incarceration can inform what interventions in custody are more likely to be successful. In addition, it is important for community health care providers to know the reasons behind diagnoses made in prison and also the medications and interventions which were provided in prison.
Transitional support

Additional, immediate and intensive support is needed during the transition from custody to the community for Aboriginal former inmates. Promoting Aboriginal former inmates’ awareness of and access to primary health care services in the community during this period is particularly important. Support during the transition period needs to be immediate and of sufficient length to meet individual needs, usually of at least six months duration. Immediate welfare needs on transition include housing, money, living skills and employment.

Transition support should involve case management and other coordinated care. For example, in custody, pre and post release support needs to be integrated and should incorporate social and mental health services in addition to substance misuse programs. Where possible family members should be involved in planning for the care received during transition as this is integral to ensuring culturally appropriate care. Effective transition support is multifaceted. Important elements include emotional (listening), informational (access to information and advice) and practical support (finances, housing, furniture). Some of the important services identified in the literature review and qualitative interviews include culturally appropriate substance misuse counselling, housing, access to children, and support in getting out of destructive relationships.

Our research emphasised the importance of comprehensive transitional support for Aboriginal former inmates. Comprehensive services are those that deal with complex multi morbidities such as mental illness, drug and alcohol and chronic disease and that view a person in their socio-cultural context. This context might include for example family relationships, culture, access to housing, income and employment.

Post-release

Aboriginal former offenders’ access to primary health care in the community is affected by multiple factors, including the quality of health care provided in custody, the extent to which health related discharge planning occurs, and access to services that meet basic needs such as housing and access to social and emotional support on release. If former inmates are not receiving holistic post release support, then accessing primary health care post release may become a lower priority compared to meeting other basic needs such as linking with family, accessing finances or accommodation.

Suggested strategies for improving Aboriginal participation in pre and post release programs and increasing their effectiveness include increasing the involvement of Aboriginal facilitators, Elders, family and community in the development and delivery of programs, and incorporating an Aboriginal world view into programs [12].

Aboriginal Community Controlled Health Services are particularly well placed to provide wide-ranging services for Aboriginal people in-custody and after release, a role which could be expanded with appropriate support and resourcing [29, 47]. The development of such a model requires access to additional long term political, financial and infrastructure support. An important first step would be enabling the use of Medicare whilst Aboriginal people are in custody.

An effective evidence-based model of primary health care for Aboriginal people released from custody might include: community in-reach, community outreach, transitional support, discharge planning, integrated drug and alcohol services and mental health care, and better linkages between in-custody and community services.
Conclusion

The lack of throughcare and transitional support leaves Aboriginal former inmates and family members feeling unsupported, acts as a barrier to accessing timely and appropriate primary health care and increases former inmates’ risk of recidivism and reincarceration. All of this contributes to the higher risk of injury and illness experienced by Aboriginal former inmates post release, and to the institutionalisation of Aboriginal people within the criminal justice system.

Primary health care has an important role to play in supporting Aboriginal people released from custody. Mainstream primary health care services generally and Aboriginal Community Controlled Health Services in particular can provide in reach services to Aboriginal people in custody. However this will not be possible unless funding constraints such as the suspension of Medicare for inmates is addressed, and unless there is an expectation and mandate for in custody health services to be culturally informed and appropriate.

Primary health care services can also contribute to release planning, and can support in custody, pre and post release programs and service delivery. If health care from custody to the community for Aboriginal former inmates is not supported then the responsibility for accessing primary health care will fall to the former inmates themselves or to family members. This reduces the likelihood of Aboriginal former inmates accessing comprehensive primary health care post release and puts them at greater risk of illness and reincarceration.

The over-representation of Aboriginal people in the criminal justice system can be linked to the marginalisation of Aboriginal Australians from mainstream services throughout their lives. Providing comprehensive and culturally appropriate primary health care to Aboriginal people in custody and post release provides an important opportunity to mitigate against this cycle of injustice.
Appendix one

References


29. Poroch, N., et al. (2011). "We're struggling in here! The phase 2 study into the needs of Aboriginal and Torres Strait Islander People in the ACT Alexander Maconochie Centre and the needs of their families". Winnunga Nimmityjah Aboriginal Health Service, Narrabundah, ACT.


46. Willis, M., Ex-Prisoners, SAAP, Housing and Homelessness in Australia. Australian Institute of Criminology, final report to the National SAAP Coordination and Development Committee, 2004: p. 136-137.


62. Poroch N, et al., We're struggling in here! The phase 2 study into the needs of Aboriginal and Torres Strait Islander People in the ACT Alexander Maconochie Centre and the needs of their families. Winnunga Nimmityjah Aboriginal Health Service, Narrabundah, ACT. 2011.

## Definitions Used in the SPRINT Project

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Aboriginal definition of health</strong></td>
<td>Aboriginal understanding of health is seen as holistic and connected to emotional cultural wellbeing. The Aboriginal Definition of Health as defined by the National Aboriginal Health Strategy (1989) has been adopted for this project. Health does not simply mean the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community. For Aboriginal people this is seen in terms of the whole-of-life view incorporating the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being and thereby bring about the total well-being of their community [63].</td>
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<tr>
<td><strong>Access to services</strong></td>
<td>Access is the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their need [66]. As such it is influenced by both provider and consumer characteristics. Andersen described a model in which health care utilisation was determined by population and health systems characteristics and being influenced by patient satisfaction and outcomes [67]. The characteristics of PHC which determine their accessibility have been described by Pechansky (1981)[68] and more recently by Rogers et al [69] and Gulliford et al [70] as:- Availability of a sufficient volume of services (including professionals, facilities and programmes) to match the needs of the population and the location of services close to those needing them; Affordability (cost versus consumers ability to pay, impact of health care costs on socio-economic circumstances of patients); Accommodation – the delivery of services in such a manner that those in need of them can use them without difficulty (e.g. appropriate hours of opening, accessible buildings); Appropriateness to socio-economic, educational, cultural and linguistic needs of patients; Acceptability in terms of consumer attitudes and demands.</td>
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<td><strong>Continuity of care</strong></td>
<td>Describes a philosophical commitment to providing consistent services and support to prisoners within and beyond prison. A holistic program of reintegration might commence at first contact between the offender and the justice system to allow the establishment of a comprehensive array of supports. Terms related to prisoner release are described in figure one below [2].</td>
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| **Coordination of care**            | This involves coordination of care between multiple providers and services with the aim of achieving improved quality of care and common goals for patients. It may involve:  
  - Case management  
  - Care planning  
  - Informal communication between workers or services  
  - Team meeting, case conferences, interagency meetings  
  - Shared assessments and records  
  - Coordination with non-health services including language services (interpreters, translated health information), formal settlement services, torture and trauma services.  
  - Referral pathways and inter-service agreements [2]. |
| **Human rights** | Human rights are fundamental, inherent, inalienable, universal, indivisible and interrelated. The right to health is set out in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 refers to the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Steps to be taken to achieve the full realisation of this right include the prevention, treatment and control of epidemic, endemic, occupations and other diseases; and the creation of conditions which would assure all medical service and medical attention in the event of sickness. Access to primary health care is identified as a core obligation under the ICESCR. Aboriginal people have the right to specific measures to improve their access to health services that are culturally appropriate. E/C.12/2000/4, para 27.

The right to health refers to a state of wellbeing, not merely the absence of disease. For example, people who are very ill cannot enjoy their right to education or participation; equally, lack of food and housing make it difficult to live in good health. Therefore the right to health is not confined to health care, but includes socioeconomic factors and determinants of health. Key elements of the right to health include timely and appropriate healthcare, as well as the availability, accessibility, acceptability and quality of health care and health determinants. |
| **Mental health** | The National Mental Health Plan 2003-2008 definition of mental health was adopted for this project. Mental health is not simply the absence of mental illness. Rather it is a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential. It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective well-being, and optimise opportunities for development and the use of mental abilities. |
| **Primary health care** | Primary health care is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. For the purposes of this project primary health care refers to those medical and health services provided in the community either through Aboriginal Community Controlled Health Services or through private general practice. The role of primary health care providers extends beyond medical care to include recognition of the social determinants such as housing and employment needs and to work with others to address these.

Our understanding of primary health care was informed by the Alma Ata definition of primary health care (1978) and Starfield’s 1998 definition of primary health care. The Alma Ata definition of primary health care (1978) is adopted for this review. Health is a fundamental human right and the attainment of the highest possible level of health is an important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.

Starfield described primary health care as being ‘that level of a health service system that provides entry into the system for all new needs and problems, provides person focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere by others’. Starfield B. Primary care: balancing health needs, services and technology. New York. Oxford University Press. 1998. |
| Throughcare | Throughcare is a process of delivering continuous care in an integrated and seamless manner throughout a prisoner's sentence and on release to the community. In theory throughcare policies will address prisoner needs from their first contact with prison and will focus on reintegration needs. Interventions need to comment in prison and continue after release. Reintegration requires close working among multiple agencies, not just correctional services. A throughcare approach also recognises that interwoven, long-term problems often require long-term solutions. The likelihood that interventions will produce positive outcomes can be increased by initiating services earlier in the custodial term. Throughcare is sometimes seen as involving a three stage process: custody (the institutional phase) – transition (placement in some sort of secure transitional facility or other preparation for release) and community release [2]. |
Appendix three: AMSWS staff and community feedback session
Sprint Findings

- Never had any real funding although G prisons in area
- In-reach programs needed
- Pre & post release support
- Discharge planning as soon as in custody
- Medicare item numbers: support continuity of care
- Close the gap
- Responsibility of transition facilitate
- Aim to halve Aboriginal incarceration rates
- Call for state and commonwealth to come together with AMS

Medicare cards taken off inmates

Medicare card is a right

Upon release need to get Medicare to help with transitional care

Make it seamless

Ask for an expansion of current Indigenous adult health check