



National Review of First Nations Health Care in Prisons: Final Report

First Nations healthcare

11 July 2024



Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of country throughout Australia. We pay our respect to Elders past, present and emerging, who maintain their culture, country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities

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Acronyms and abbreviations

Term	Detail
ACCHO	Aboriginal Community Controlled Health Organisation
ACT	Australian Capital Territory
Agreement	National Agreement on Closing the Gap (2020)
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
AOD	Alcohol and other drugs
FASD	Foetal Alcohol Spectrum Disorders
GP	General Practitioner
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NSW	New South Wales
NT	Northern Territory
PBS	Pharmaceutical Benefits Scheme
PWID	People who inject drugs
QLD	Queensland
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SAPHS	South Australia Prison Health Service
VIC	Victoria
WA	Western Australia

About this report

The purpose of this report is to present evidence and key recommendations on the opportunities for systemic reform at the national, state and territory levels to improve health care delivery for First Nations people in places of detention.

The recommendations presented in this report have been developed through a review of evidence collected from desktop review and stakeholder engagement, and in consultation with stakeholders from communities, delivery, advocacy and government. This review recognises the importance of the outstanding recommendations from Royal Commissions and coronial inquests and does not seek to replace those actions but rather presents an agenda for reform specific to the delivery of health care in places of detention.

Acknowledgements

The Nous and Ngarra Group teams who worked on this review want to acknowledge the critical input into the project from all stakeholders and informants. In particular, those First Nations people who gave their time to meet with us and provide their insights, tell their stories, and contribute to our thinking and analysis. Nous and Ngarra Group recognise that the experience of First Nations people with the justice system continues to be a traumatic one and that advocates and activists have long called for change in this space. Few of our families have escaped the negative impacts of this interaction and the incarceration of too many of our people.

In this context, reviewing the delivery of health services to First Nations people in places of detention is a complex task because the issue is not a straightforward one and slow progress, or lack of it, is deeply frustrating. The willingness of people to engage with this review is an indicator of its importance and to do so at this point in the history of this nation has been truly amazing. While this is not the first piece of work in this area, we hope that it will provide a solid platform for advancing the key issues that have been identified in the work that came before this review and will guide any work that follows.

This report is the outcome of a review undertaken by Nous in association with Ngarra Group. The review was jointly led by Nous and Ngarra Group and the views in this report are the views of both Nous and Ngarra Group.



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Executive summary

This review has been conducted within the much broader context of First Nations justice and health.

This National Review of First Nations Health Care in Prisons has been commissioned to examine a very specific challenge within the broader First Nations justice and health context. This report presents findings and recommendations guided by the review's key lines of enquiry, while also recognising that there are distinct challenges within the broader operating environment that impact on the ability for progress to be made in this area.

This review consistently heard the frustration of stakeholders in the apparent non-implementation of the Royal Commission into Aboriginal Deaths in Custody (RCIADC) recommendations despite the at least 517 Aboriginal deaths in custody since they were handed down.¹ There are clear recommendations that have come from this Royal Commission and others, as well as coronial inquests into deaths in custody, that stakeholders report have not been sufficiently implemented to affect change for First Nations people in places of detention.

There have been heightened sensitivities and complexities flowing from the outcome of the Voice Referendum in 2023. Stakeholders have reported the negative impact that this has had on their staff delivering services on the ground, as well as a potential organisational resistance to working with government. This may present a challenge for the engagement and partnership required with Aboriginal and system leaders required in the implementation of the review's recommendations.

Similarly, the 2024 release of the Productivity Commission's first Review of the National Agreement on Closing the Gap showed that governments are not adequately delivering on their commitments and have not produced 'improvements that are noticeable and meaningful for Aboriginal and Torres Strait Islander people'.² It was reported that there has been insufficient focus on Priority Reforms, including calling-out recent government decisions that have exacerbated rather than remedy, disadvantage and discrimination. Youth justice was highlighted as a particular example.

The Productivity Commission also highlighted the lack of progress towards Priority Reform 1: Shared decision-making and Priority Reform 2: Building the community-controlled sector, observing that it remains a critical challenge for modern public policy design and administration. Genuine co-design and partnerships that empower First Nations people to share decision-making authority with governments are key to accelerating progress in priority reform areas and have been included in this report as critical elements within the recommendations.

First Nations people face additional barriers to health care, and feel additional harm through disconnection from culture, family and ways of being.

There are universal challenges within places of detention that impact on prisoners' and people on remand's ability to access quality healthcare services to meet their needs. For First Nations people, these challenges are compounded by additional barriers resulting from the systemic racism and

¹ Victorian Aboriginal Legal Service, 2022, Community fact sheet: Ending Aboriginal Deaths in Custody

² Review of the National Agreement on Closing the Gap, 2024

harmful attitudes that work to further restrict access to health care. Coronial inquests have highlighted the challenges that First Nations people have in the greater likelihood of their health requests being dismissed, and informants to this review reported that First Nations people in places of detention feel that requests for help are more likely to receive a punitive rather than therapeutic response.

As the world's oldest continuous living culture, First Nations people also have deep cultural obligations, connections and ways of knowing and being. This exists in sharp contrast to their experience in modern Australia, which includes a history of negative engagement with government systems, police and places of detention. This lived reality makes incarceration additionally challenging and traumatising for First Nations people.

It is also recognised that there are increased rates of disability and complex health needs within this population that further exacerbate the challenges faced in custodial settings.³ This requires a specific and needs-based approach that addresses the complexity of delivering culturally safe care.

Recognising the wisdom, strength and knowledge of First Nations people to lead, design and implement improvements for their mob is critical to effective change.

Genuine partnerships that elevate the voices of First Nations people and empower communities to bring their ways of knowing and being to shared decision-making with governments is central to driving change. It is only through the realisation of the Closing the Gap commitment to build and strengthen structures around meaningful partnerships that effective action will occur.

Recommendation 3 in this report is centred on this idea and proposes a formal mechanism through which this can be achieved for health services delivered in places of detention.

Supporting improved health care for First Nations people in places of detention requires system level change.

In examining and making recommendations to improve health outcomes for First Nations' people in places of detention, we have made system-wide recommendations. The review recognises that implementing changes to support the improved quality of health care for this population would also benefit the general custodial population if applied more broadly.

Places of detention are managed, operated and delivered at a state and territory level. Whilst the principle of 'equivalence' to care is legislated in most jurisdictions there is variability in the model of care and how healthcare services are delivered. There is limited data to ascertain the quality and impact of these healthcare services on the improvement of health outcomes for First Nations people. This review recommends system level change to remedy this variation and improve transparency, accountability and the ability to measure impact.

This review gathered evidence from published literature, key informants and roundtable meetings.

This report is one of three key deliverables in this review, which has also included a Literature Summary (Attachment 1) and a Consultation Summary (Attachment 2). The Literature Summary

³ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2023, Volume 8: Criminal justice and people with a disability

examined peer reviewed literature, Royal Commissions, coronial inquests, grey literature and other key documents to develop an evidence base that was further explored through stakeholder engagement.

Given the review timeframe, consultations were conducted with a targeted number of stakeholders. The review sought input from stakeholders through individual and group engagements across the health, justice and Aboriginal community-controlled sectors. A full list of stakeholders is at Appendix C. This included consultations with health and justice departments in each jurisdiction, which provided more detailed information on current services across the country.

Four roundtable meetings were held in WA, ACT, NT and VIC, bringing together a diverse range of stakeholders in person, to refine the key opportunities for change that have formed the basis of the six overarching recommendations, and to develop the principles for reform presented in Recommendation 1.

While there was no formal ethics approval sought for this review, the voices of people with lived experience have been included in this report through participation in roundtable meetings as members of representative organisations. The review methodology was also designed to ensure that evidence included the voices and experience of First Nations people in respect and recognition of their history and depth of knowledge in this area. This includes recognising the strengths of First Nations people in the leadership and design of the most effective solutions for their communities.

Six recommendations to address system level issues have been presented for consideration.

The review heard and considered opportunities and issues across all elements of the custodial system, including but not limited to continuity of care issues, remand, and special populations. To capture the detail of what the review heard, while maintaining focus on system level change, this report has been structured to outline both a system-wide approach and a national program of work contained in a defined set of recommendations. Investing in principle-led reform, with the right people around the table focusing on system transparency, data, quality standards – and a structure and process inclusive of all governments – maximises the chance that reform will be real and effective. In the end it is improving the health of all people who connect with the custodial system that will be the test of effectiveness.

In addition, there is a breadth of stakeholder input and issues that informed the development of system responses. This is captured in the Consultation Summary (Attachment 1) and details the richness of the input and advice we received.

This report outlines a suite of six overarching recommendations that should be considered for implementation. These are summarised below in Figure 1 and discussed in detail in Section 3.

Figure 1 | Summary of review recommendations



1 Introduction

This section provides an overview of the purpose of the review and the approach taken for research, engagement and analysis, and discusses the limitations of the methodology.

1.1 Background and context

The National Aboriginal and Torres Strait Islander Health Collaboration recommended an independent review of health care provided to First Nations people in places of detention, i.e. adult prisons, remand centres and youth detention facilities across Australia to understand the current state of healthcare delivery in these settings and identify opportunities and barriers for reform. In November 2023, the Australian Department of Health and Aged Care (the Department) engaged Nous Group (Nous) to undertake this independent, national review of health care in prisons for First Nations people (the review).

This National Review of First Nations Health Care in Prisons has been commissioned to examine a very specific challenge within the broader First Nations justice and health context. This report presents findings and recommendations guided by the review's key lines of enquiry, while also recognising that there are distinct challenges within the broader operating environment that impact on the ability for progress to be made in this area.

This review consistently heard the frustration of stakeholders in the apparent non-implementation of the Royal Commission into Aboriginal Deaths in Custody (RCIADC) recommendations despite the at least 517 Aboriginal deaths in custody since they were handed down.⁴ There are clear recommendations that have come from this Royal Commission and others, as well as coronial inquests into deaths in custody, that stakeholders report have not been sufficiently implemented to affect change for First Nations people in places of detention.

There have been heightened sensitivities and complexities flowing from the Voice Referendum defeat in 2023. Stakeholders have reported the negative impact that this has had on their staff delivering services on the ground, as well as a potential organisational resistance to working with government. This may present a challenge for the engagement and partnership required with Aboriginal and system leaders required in the implementation of the review's recommendations.

Similarly, the 2024 release of the Productivity Commission's first Review of the National Agreement on Closing the Gap showed that governments are not adequately delivering on their commitments and have not produced 'improvements that are noticeable and meaningful for Aboriginal and Torres Strait Islander people'.⁵ It was reported that there has been insufficient focus on Priority Reforms, including calling-out recent government decisions that have exacerbated rather than remedy, disadvantage and discrimination. Youth justice was highlighted as a particular example.

⁴ Victorian Aboriginal Legal Service, 2022, Community fact sheet: Ending Aboriginal Deaths in Custody

⁵ Review of the National Agreement on Closing the Gap, 2024

The Productivity Commission also highlighted the lack of progress towards Priority Reform 1: Shared decision-making and Priority Reform 2: Building the community-controlled sector, observing that it remains a critical challenge for modern public policy design and administration. Genuine co-design and partnerships that empower First Nations people to share decision-making authority with governments are key to accelerating progress in priority reform areas and have been included in this report as critical elements within the recommendations.

1.2 Review governance

This review was undertaken by a consortium with Nous and Ngarra Group with ongoing input from a project Advisory Group. The purpose of the Advisory Group was to ensure that diverse perspectives and knowledge of subject matter experts were embedded in the review. The Advisory Group provided guidance on interpretation of the review findings and advice on the final recommendations presented in this report. The Advisory Group was not a decision-making group nor a primary mechanism for stakeholder engagement for the review.

1.3 Review methodology

The purpose of this review was to identify the barriers to effective, culturally safe health care for First Nations people in places of detention and to present recommendations for systemic reform at the national, state and territory levels.

See Appendix B for detailed review methodology. The review explored four key lines of enquiry (KLEs), which guide the findings presented in Section 2. The KLEs are:

1. **What health services are delivered in custodial settings for First Nations people (adults and youth)?**
2. **What inequities exist in the accessibility of health care services offered to First Nations people in custody compared to services available outside of prison?**
3. **What barriers exist to effective, culturally safe health care for First Nations people in custody?**
4. **What opportunities exist for innovation and reform across states, territories and nationally?**

This final report is the last of four key deliverables, which have also included a Literature Summary (Attachment 1), Consultation Summary (Attachment 2) and draft report. Inputs into the review findings and recommendations have come from 32 stakeholder consultations, four roundtable consultations, over 120 documents reviewed and a series of project Advisory Group meetings.

1.3.1 Key definitions used in this review

This review takes a whole-of-life view to health that refers to the social, emotional and cultural wellbeing of First Nations communities.

The concept of 'health' is recognised by First Nations Australians as a holistic sense of wellbeing, with links to social, emotional, cultural, mental, physical and spiritual health. This understanding differs from the non-Indigenous concepts of health that have historically informed the design of the

public health system in Australia, which generally apply a medical and diagnostic lens to health care. As a result, mainstream public health services predominantly do not provide the range and cultural orientation of services that would be identified if a more comprehensive First Nations definition were used. When talking about health, health outcomes and healthcare services in this report, the below definition of health from National Community Controlled Health Organisation (NACCHO) can be assumed.

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

Aboriginal community controlled health organisations (ACCHOs)

This review also references Aboriginal community controlled health organisations (ACCHOs) throughout the findings and recommendations. ACCHOs are defined as health and wellbeing services that are led by First Nations people and guided by First Nations principles of social and emotional wellbeing to provide a holistic model of care. These services typically include multiple health and social services to provide comprehensive primary care to individuals and communities.

Places of detention

This report primarily uses the term 'places of detention' to describe the settings examined in this review. This is inclusive of adult prisons, remand centres and youth detention facilities across Australia. At the commencement of the review, the terminology used was 'custodial settings' or 'prisons', however it has been noted that a more comprehensive definition of places of detention is appropriate and in line with international guidance on the subject. 'Prison' and other terms may be used when they are direct references to datasets or published literature.

Article 4 of the Optional Protocol to the Convention against Torture (OPCAT) provides a specific definition of places of detention: "Any place under its jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence. Deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative, or other authority."⁶

1.4 Limitations of the review

Stakeholder engagement was within the parameters and timing of the review.

This review has drawn on evidence from desktop analysis and stakeholder consultation to develop recommendations for reform within a tight project timeframe (December 2023 – June 2024). As presented above in Section 1.3, there was limited time to engage broadly, and therefore targeted

⁶ Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199, adopted 18 December 2002

consultation was undertaken with stakeholders from Australian, state and territory governments, Aboriginal community controlled organisations, service delivery organisations and subject matter experts to gain a diverse range of perspectives. While consultation was as broad as possible, there were some limitations to the number of voices that could be added to this review.

Efforts were made to engage with people with lived experience. The timing of the review precluded the ability to attain ethics clearance and so the review limited engagement to advocacy organisations and those who were already active participants in advocacy to ensure consultations were consistent with an ethical approach. This includes people from the sub-populations that were identified in the review, specifically young people, people living with disability, and people who have experienced alcohol and other drug addictions.

Similarly, this review did not interview individual corrections staff or healthcare providers, who may have provided more granular operational detail. The Nous review team did not visit any places of detention and were unable to view their health care settings or operations.

The settings examined in this review were limited to specific places of detention.

As noted in the above section, the definition of places of detention is broad and captures facilities governed by a jurisdiction where an individual is deprived of their liberty. This review focused specifically on adult custodial facilities, youth detention facilities and remand centres, and did not explore other settings such as police watchhouses. The review also did not speak to representatives from the police.

This report seeks to present as comprehensive a review as possible within the project timeframe, noting that any further work to refine and implement the recommendations in this report will require continued and broader engagement with the stakeholder groups outlined above.

The review has focused on issues raised by stakeholders, and aims to be a true reflection of what was heard through the consultation process.

There are additional issues that the review is aware of regarding access to healthcare services in places of detention that are not explored in this review. For example, palliative and end of life care is a service that is available to people in places of detention, however this was not raised by any of the stakeholders during the consultation process and therefore has not been discussed in this report. The Consultation Summary (Attachment 2) provides a more comprehensive overview of what was heard from stakeholders during consultations.

There is opportunity to further explore the issues faced by First Nations people with disabilities in places of detention.

The scope of this review was to explore the delivery of healthcare services to First Nations people in places of detention, however the issue of access to appropriate disability services and supports was also consistently raised through consultations. This report notes these issues as raised by stakeholders but has not explored specific opportunities for reform in depth in the contained recommendations given the scope of this project.

2 Review findings

This section provides an overview of findings against the KLEs for this review, it includes:

- health services delivered in places of detention for First Nations people
 - inequities in the accessibility of healthcare services
 - barriers to effective, culturally safe health care
 - opportunities for innovation and reform.
-

2.1 Health services currently delivered in places of detention for First Nations people

Governance, design and delivery of First Nations health services varies across jurisdictions and locations with limited involvement from ACCHOs.

States and territories have operational responsibility for the provision of all health services in places of detention. This includes services such as primary, dental and mental health care.

There is currently no comparable national data on the volume, quality and accessibility of healthcare services being delivered in places of detention across jurisdictions. As part of this review, states and territories provided information on the types of services they provided using the NACCHO core services model as a guide. This revealed a level of consistency in availability of several services across jurisdictions, including nurse-led primary care services, emergency care, clinical management (e.g. chronic conditions), mental health and psychiatric care, preventive care and assessments (e.g. immunisations, screening), substance use programs and transitional care; however there is not a sufficient level of detail (or benchmarks) to compare level, access or quality of services. There is also a lack of clear information on the extent to which cultural safety is embedded within these services.

Few jurisdictions have adopted a First Nations-specific model of care, and healthcare services are delivered to First Nations people through a combination of providers including public health services, private providers and ACCHOs. For example, in the ACT and NT, Winnunga⁷ and Danila Dilba⁸ are two ACCHOs that provide in-reach health services directly to First Nations people who choose to use their services in the Alexander Maconochie Centre and Don Dale Youth Detention Centre, respectively.

At a national level, accessible data reveals that in 2022, only nine per cent of First Nations people reported receiving health care from an ACCHO while in prison.⁹ In states where specific health services delivered by a government justice health team (NSW and SA), ACCHOs may be involved as throughcare providers. For example, Waminda is an ACCHO in NSW that delivers a program to

⁷ Winnunga Nimmityjah Aboriginal Health and Community Services, ACT

⁸ Danila Dilba Health Service, NT

⁹ AIHW, The health of people in Australia's prisons 2022, Australian Government, Canberra, 2023.

support First Nations women transitioning back to the community post-release from custody. Other services specific to First Nations health and wellbeing are delivered on an ad hoc basis in specific regions across Australia, such as Marumali, an ACCHO that provides essential healing programs in Victorian prisons to support people in places of detention to reconnect with their spiritual and cultural identity.

Aboriginal Health Worker (AHW) positions are common roles in places of detention across Australia, particularly where there is limited in-reach activity from ACCHOs (e.g. in NSW, WA, Qld and Vic).¹⁰ Queensland and NSW also have specific roles for First Nations mental health workers. Most states and territories employ Aboriginal Wellbeing/Liaison Officers (or equivalent), a role which focuses on cultural and wellbeing support for people in places of detention. Youth justice workers are also commonly employed in youth detention centres to provide day-to-day support to maintain the physical and psychological wellbeing of young people. The extent to which people in these roles are involved in healthcare delivery varies. Stakeholders highlighted that these positions in places of detention are challenging to fill and retain.

The location of service delivery also varies by individual places of detention across states and territories. Certain custodial facilities (e.g. Long Bay Correctional Complex, NSW) have well-equipped onsite medical clinics that enable the provision of a large suite of services within the one facility, including in-house primary care, hospital care, and specialist mental health care. Other facilities are less equipped, particularly in youth detention facilities, and rely on accessing external services in the community.

Health care in places of detention is reactive and anchored in clinical or custodial need; it is rarely proactive, holistic or driven by a First Nations model of care.

Health services in places of detention across Australia are largely delivered through a mainstream, medical model of care. This model does not reflect the First Nations definition of health that encapsulates a holistic understanding of social and emotional wellbeing, driven by connections to community, culture, Country, kin and self (mind and body). As a result, identified health conditions are treated through a medical lens and in isolation to broader personal and systemic (sociocultural, historical, political) factors that contribute to the health outcomes of First Nations people in places of detention.

Health care is also largely reactive to individual requests and perceived clinical urgency, triaged by correctional officers. This requires a sound level of health literacy amongst individuals who request health care and supervising correctional officers who are required to triage those who do not actively request attention. This is particularly difficult for people with disabilities who, in the community, typically have the support of family or carers to facilitate health care. In the NT, an electronic medical system within places of detention includes a “callback” function that enables clinicians to proactively follow-up on individuals with chronic health conditions. This is not common across all jurisdictions, with many still relying on a paper-based medical record system.

¹⁰ NSW, WA and Qld roles are employed by state government departments; Vic roles are employed by private prison operator, GEO

Many stakeholders raised the issue of a lack of appropriate mental health care. There is recognition that while mental health services may be available in places of detention, they are often focused on reducing criminogenic behaviours rather than operating through a therapeutic model of health care that has a primary goal of improving the patient's health and wellbeing. In addition, the challenges in accessing psychology services within the mainstream community is equally, if not more of an issue within these environments where the likely need is higher.

Stakeholders provided other examples of services that can be meeting 'custodial' rather than health need. This included a higher rate of prescribing medications that may produce a sedative effect and moderate behaviours for people in places of detention compared to the mainstream population.

In some states and territories, elements of a First Nations approach to health care have been included in custodial health services through the involvement of ACCHOs such as Winnunga or Danila Dilba, through the provision of direct in-reach services at specific facilities. In SA, the South Australia Prison Health Service (SAPHS) is unique in its adoption of a 'Model of care for Aboriginal prisoner health and wellbeing for South Australia',¹¹ prepared by Wardiparingga Aboriginal Health Research Unit. However, stakeholders reported that its specificity is a challenge to broader implementation outside of the state.

Initial assessments at reception are not effective in comprehensively identifying complex health needs and informing ongoing care.

All people entering places of detention undergo an initial health assessment process that informs which services are required for the duration of their sentence. These assessments generally screen for chronic health conditions, mental illness, drug and alcohol dependency, and current medications. First Nations people entering places of detention may also have the option to undergo a separate assessment comparable to the Aboriginal and Torres Strait Islander Peoples Health Assessment (MBS Item 715), however this may not always be made clear to people as they enter a facility.

Due to a lack of integration with the broader health system, initial assessments rely on individuals to understand and report their health conditions and medications to the facility health service rather than connecting with health records or directly with clinicians who are managing an individual's care in the community. This approach relies on a level of health literacy that is not always common among this population, and individuals are often apprehensive to declare certain conditions, such as illicit drug use or mental health challenges, out of fear of attracting punitive action.

Stakeholders reported that the questions asked during screening reflect the limited range of services available to address any identified clinical needs, rather than seeking to proactively identify issues that may require a more complex, long-term health or wellbeing response. Stakeholders also argued that assessments are not comprehensive enough to capture the wide-ranging needs of the facility population, including the identification of neurological conditions and disabilities, nor do

¹¹ Wardiparingga Aboriginal Health Research Unit. Model of care for Aboriginal prisoner health and wellbeing for South Australia. South Australia Health and Medical Research Institute (SAHMRI). Adelaide, November 2017.

they support a holistic approach to understanding social and emotional wellbeing. The extent to which the findings of initial assessments are applied to clinical responses also reportedly, greatly varied across facilities.

2.2 Inequities in the accessibility of health care

Inequities in the accessibility of health care are the differences in health care available in places of detention compared to what is available in the community. Comparing health service access in and outside of places of detention is complex. Health services are not uniformly available – and even when they are available – not uniformly accessed.

For a proportion of the population, a place of detention can be the first time services are accessed and conditions are treated. For instance, 75 per cent of First Nations people in custody reported consulting a health professional in prison, whereas only 63 per cent of First Nations people in custody reported consulting a health professional in the community in the previous 12 months.¹² For others, the nature of their care is diminished in places of detention – with medications being changed and the choice of provider removed. In some health categories such as therapeutic mental health, there are shortages in places of detention as well as in community settings. Overall, however, the custodial environment was described by stakeholders as inherently harmful to health and one that further contributes to First Nations dispossession and disconnection from their community and culture.

Custodial staff and security requirements inhibit access to effective, culturally appropriate health care.

There are inherent limitations associated with the deprivation of liberty in places of detention that mean that First Nations people in custody are limited in their agency and self-determination regarding their own treatment, medication, nutrition and engagement in behaviours that pose a health risk.

One of the main restrictions is that custodial staff often act as the triage point or ‘gatekeeper’ for health requests and may filter out genuine requests for health care or override instructions from health professionals. This is predominantly the case where custodial staff do not have appropriate training to recognise health issues or engage with First Nations people in a manner that is culturally appropriate or safe.¹³ The power that custodial staff have over individuals is unique to the custodial system – people in places of detention have to rely on another person that is not necessarily obligated to act in their best interests to support their access to health.

The controlled movement through correction centres and between facilities often results in slow escalation of acute cases and poor outcomes for individuals, as they must undergo several

¹² AIHW, The health of people in Australia’s prisons 2022, Australian Government, Canberra, 2023.

¹³ A Capon et al., Prisoners’ experience and perceptions of health care in Australian prisons: a qualitative study, International Journal of Prison Health, 2020, 16(3); NACCHO, Standards for Health Services in Australian Prisons: Submission to RACGP, NACCHO, 2022.; Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021; S Kendall et al., Incarcerated Aboriginal women’s experiences of accessing healthcare and the limitations of the ‘equal treatment’ principle, International Journal for Equity in Health, 2020, 19(48).

touchpoints and security measures before gaining access to the care they need in an emergency.¹⁴ Additionally, facility operating procedures, unscheduled lockdowns and out-of-cell hours also may impact the ability of individuals to access health care, and for health staff and in-reach services to reach their patients.¹⁵

The presence of officers in medical appointments and use of physical restraints also inhibits the ability for health staff to build rapport and establish trust with their patients. Custodial staff may also be privy to confidential medical information, impacting on how safe or open people may feel in disclosing personal information. While security requirements may be necessary to ensure the safety of staff, these may be excessive with respect to the risk the person poses and disincentivises access.¹⁶

Examples provided to the review where interactions with custodial staff or certain procedures inhibit access, quality or delivery of health care include:

- Women being shackled during childbirth for the security of health staff and the immediate removal of their children at birth for the safety of the child traumatises the woman and impacts the wellbeing of the child.
- Women needing support for 'women's business' may have to request care through a male guard who may hold racist views as well as disdain towards 'prisoners'. This dissuades disclosure, reduces trust in the system, and leads to poor health outcomes. Needing to disclose the reason for access to a non-health professional violates the woman's privacy.
- Seeking assistance for a drug or alcohol issue triggering a punitive response from custodial staff including moving to more secure accommodation, preventing access to other support services or opportunities like employment.
- Seeking help for a mental health issue may trigger transfer to solitary confinement for 24 hours of monitoring and surveillance, which further exacerbates mental ill health.
- Complaining about current care leading to lack of access and/or repercussions as opposed to the intended outcome of improving the service.
- Individuals must surrender glasses, prosthetics and medications for their and others' security.
- Visits from advocates are held in open areas where confidential conversations are overheard by staff and may lead to repercussions.

¹⁴ J Olds et al., Exploring barriers to and enablers of adequate healthcare for Indigenous Australian prisoners with cancer: a scoping review drawing on evidence from Australia, Canada and the United States, Health & Justice, 2016, 4(5); S Pettit et al., Holistic primary health care for Aboriginal and Torres Strait Islander prisoners: exploring the role of Aboriginal Community Controlled Health Organisations, Australian and New Zealand Journal of Public Health, 2019, 43(6).

¹⁵ Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021.

¹⁶ Office of the Inspector of Custodial Services, Routine restraint of people in custody in Western Australia, Queensland Government, 2020; Cultural review of the adult custodial corrections system, Victorian Government, 2023.

Lack of adequate services to support people with disability, mental health issues and other complex needs.

Certain health needs are not being met for specific groups of people within places of detention. Women were identified to have more complex mental health and trauma-related needs than men,¹⁷ requiring longer appointments and more follow up. These women have often experienced significant trauma, exposure to family violence and the removal of their children. The issue of dignity for women and girls in places of detention was raised consistently by stakeholders, who reported the severe impacts on social and emotional wellbeing. For example, stakeholders told us of women who had experienced supervised showers, strip searches following family visits and limited access to sanitary products, all of which is detrimental to a woman's wellbeing and undermines their trust in the system.

The most consistently reported issue for young people in detention is the disproportionately high rates of fetal alcohol spectrum disorder (FASD) and other neurodevelopmental conditions.¹⁸ It was found that correctional staff are often not trained to identify certain behaviours as a clinical symptom – rather viewing them as defiance. Additionally, there is a severe shortage of health workers in youth detention, meaning that young people are often taken to outpatient services to receive health care. Stakeholders have observed that staff in these health services and emergency departments are less willing to provide care to young people who are in places of detention and less likely to take the health needs of young people seriously even when there was risk of self-harm.

Cognitive disability (diagnosed and undiagnosed) is severely overrepresented in the custodial system, especially for First Nations people,¹⁹ characterised by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability as a 'hidden national crisis'.²⁰

In the custodial system, disability care is not considered to be health care, and often falls through the cracks between services provided by either the health or justice departments. It was found that this leaves people with disabilities without the supports they require. Stakeholders also reported that there is a significant issue with people with disabilities losing self-determination in their care through either having to identify themselves as a First Nations person or 'disable' themselves to access specific programs and equipment.

For people living with addiction, there is stigma around alcohol and drug use/dependencies in places of detention. Facilities generally adopt a prohibitive model, rather than focusing on harm minimisation (as is predominantly done in the community). Community alcohol and other drugs (AOD) treatment programs need to be significantly adapted to adhere to the security and risk requirements of facilities, while other treatments are entirely unavailable. Some measures to reduce health risk behaviours that may seem reasonable in mainstream society (e.g. smoke-free facilities)

¹⁷ AIHW, Improving mental health outcomes for Indigenous Australians in the criminal justice system, Australian Government, Canberra, 2021.

¹⁸ RA Pedruzzi, et al., Navigating complexity to support justice-involved youth with FASD and other neurodevelopmental disabilities: needs and challenges of a regional workforce, Health Justice, 2021, 9(8).

¹⁹ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Final Report, 2023.

²⁰ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Final Report, 2023.

are having the opposite effect and are driving people to seek more harmful drugs. Stakeholders reflected that it can be easier to access drugs in places of detention than in the community. This also exacerbates the risk of recidivism for people in throughcare programs, where drug use is a breach of bail conditions and can result in re-incarceration, even if the person's prior crime was not a drug offence.

Health services in places of detention are often not culturally appropriate or safe.

This review found that in general, the health services provided in places of detention are not designed to comprehensively meet the needs of First Nations people.²¹ In 2022, 65 per cent of First Nations people exiting a prison reported receiving culturally appropriate care, though only 26 per cent stated they received treatment or consultation from an ACCHO and/or Aboriginal Medical Service (AMS).²² This is in contrast to health care in the community where ACCHOs currently service about 46 per cent of Aboriginal and Torres Strait Islander people.²³ The lack of ACCHO-delivered health care limits the degree to which health care provided in places of detention can be assessed as culturally appropriate.

There is also a lack of First Nations staff working in the custodial system, with high numbers of vacancies and attrition rates both in health care and other support or liaison roles.²⁴ Custodial staff generally experience high levels of risk, stress and trauma – this burden is heightened for First Nations staff who also face racism, discrimination, high workloads, heavy cultural load and burnout.²⁵ The shortage of First Nations staff inhibits the ability to promote engagement with health services and deliver culturally safe health care to First Nations people in places of detention.²⁶

Accessing healthcare services in places of detention often requires a more advanced health literacy than in the community. This may translate to a greater difficulty in navigating the procedures to request and receive health care. First Nations people reported a lack of orientation of custodial health services, finding it difficult to access information.²⁷ Literacy challenges and the need for self-diagnosis in submitting request forms also inhibits access as acceptance of the request is

²¹ Royal Commission into the Protection and Detention of Children in the Northern Territory, Australian Government, 2017; Coroners Court of Victoria, Inquest into the Passing of Veronica Nelson, 2023; Cultural Review of the Adult Custodial Corrections System, Victorian Government, 2023; Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021; PwC and Department of Health, Clinical Excellence Division, Offender Health Services Review, Queensland Government, 2018.

²² AIHW, Health of people in Australia's prisons, Australian Government, 2023.

²³ AIHW, Aboriginal and Torres Strait Islander specific primary healthcare: results from the OSR and nKPI collections, 2024.

²⁴ Cultural Review of the Adult Custodial Corrections System, Victorian Government, 2023; Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021.

²⁵ Cultural Review of the Adult Custodial Corrections System, Victorian Government, 2023.

²⁶ Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021; Perdacher, E et al., Well-being and mental health interventions for Indigenous people in prison: systemic review, *BJPsych Open*, 2019, 5(6); Askew et al, To your door: Factors that influence Aboriginal and Torres Strait Islander peoples seeking care, Kanyini Qualitative Study Monograph Series: No.1, 2014.

²⁷ S Kendall et al., Incarcerated Aboriginal women's experiences of accessing healthcare and the limitations of the 'equal treatment' principle, *International Journal for Equity in Health*, 2020, 19(48).

dependent on the individual being able to identify and articulate their needs and urgency.²⁸ Certain cultural protocols around sharing personal information may also result in First Nations people not receiving culturally appropriate support or feeling able to communicate freely about health needs.²⁹ This also extends to making complaints – stakeholders highlighted that it is difficult to raise concerns regarding health care in places of detention due to a lack of effective complaint pathways and the potential for repercussions if complaints were raised.

In the majority of cases, health services are not available to people on remand.

Stakeholders reported that the lack of health services available to people on remand is a significant gap in care provision within the custodial system. First Nations people are disproportionately represented at 36 per cent of the total remand population.³⁰ People are usually in remand for short amounts of time (median time is 3.1 months)³¹ and this rapid churn means that although many people entering remand undergo an initial screening assessment, they are unable to get established care and often ineligible for ongoing treatments.³² On the other hand, with court backlogs there are individuals who may wait in remand for over several months or a year and their ineligibility for health programs such as alcohol and other drugs (AOD) treatment severely impacts on their health for significant periods of time. Additionally, there tends to be little to no notice when people on remand are released, resulting in a lack of discharge planning or reintegration support on release.³³ Stakeholders also raised that individuals released from remand may not be eligible for throughcare programs, meaning there are times where people on remand experience greater disruption and disadvantage than those who have been sentenced.

Inadequate funding arrangements lead to limited access and poorer quality health care than available in the community.

In the community setting, people can access a range of funded health and medical care services, including Medicare subsidised services. Medicare services are subsidised by the Australian Government and where the health practitioner accepts the Medicare rebate for the full cost of the service, the service is said to be bulk-billed, resulting in patients not having any out-of-pocket costs.³⁴ Eligibility for Medicare also provides access to the Pharmaceutical Benefits Scheme which subsidises the cost of medications listed as part of the scheme.

In comparison, healthcare services in places of detention are funded by the relevant state and territory through block funded arrangements. Health expenditure is currently not consistently

²⁸ Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021; PwC and Department of Health, Clinical Excellence Division, Offender Health Services Review, Queensland Government, 2018.

²⁹ Cultural Review of the Adult Custodial Corrections System, Victorian Government, 2023.

³⁰ ABS, Prisoners in Australia 2023, 2024.

³¹ ABS, Prisoners in Australia 2023, 2024.

³² AIHW, Improving mental health outcomes for Indigenous Australians in the criminal justice system, Australian Government, Canberra, 2021.

³³ AIHW, Improving mental health outcomes for Indigenous Australians in the criminal justice system, Australian Government, Canberra, 2021.

³⁴ Department of Health and Ageing, About Medicare, Australian Government 2024, accessed January 19 2024. [About Medicare 2024].

captured and measured across jurisdictions and therefore it is difficult to make assertions regarding the specific level of funding provided to support health care provision in these settings – however, the inadequacy of funding allocated to support health care was a consistent theme heard across all consultations and roundtable meetings. This inadequacy has been attributed to the exclusion of the Medicare Benefits Schedule for custodial health services and barriers to accessing medications through the Pharmaceutical Benefits Scheme. Although the review concluded that the issue of quantum of funds required to support high quality health care and the mechanism for that funding being available either to individuals or the system, should be considered as separate issues.

Medicare and Medicare Benefits Schedule:

The issue of the lack of access to Medicare in places of detention is raised in several ways (Table 1).

Many stakeholders see this as a rights-based issue, with access to Medicare seen as linked to the right of any Australian citizen – regardless of the setting. The lack of access to MBS funding also restricts individual funded access to subsidised allied health and medical specialist care and has implications for the Pharmaceutical Benefits Scheme (PBS). The current change of funding model for places of detention can also provide a barrier to treatment carrying over from the community – such as health assessments, health care plans and mental health plans. This results in the need to undertake multiple assessments pre and post release to direct care planning either while detained or when leaving the place of detention to support access to subsidised clinical and allied healthcare services.

An incarcerated person remains eligible for Medicare and does not lose their entitlement when they enter a place of detention. However, custodial health services cannot receive Medicare Benefits Schedule (MBS) rebates for their services. S19(2) of the Health Insurance Act 1973 (the Act) prevents state and territory governments from transferring health care costs associated with their custodial health services to the Australian Government Medicare program, as they are services rendered by, on behalf of, or under an arrangement with a state or territory government authority.

Table 1 | Summary of key issues raised by stakeholders in regard to Medicare

Medicare is seen as a right of all Australians	<ul style="list-style-type: none"> • This this right is taken away when in a custodial system is 'not fair' and limits access to care. • For some people, providing MBS to people in custodial systems will mean more care will become available. A 19(2) exemption is the vehicle to allow that to happen so that is the 'called for' way forward.
Medicare is your gateway to more detailed care assessment and planning	<ul style="list-style-type: none"> • For example, chronic care planning and mental health care planning leads to access to allied health services like psychological services.
Medicare is your access to PBS subsidised medications and tertiary care	<ul style="list-style-type: none"> • Once in a state system, medications can be changed to a cheaper product • The 'full cost of the medicine' rather than the PBS co-payment is required.
Medicare rebates are not sufficient to fully support access to private providers	<ul style="list-style-type: none"> • On its own, it is not sufficient funding to attract practitioners into custodial settings. • Offering services in this way could fragment existing services.

Pharmaceutical benefits scheme:

The Health Insurance Act 1973 does not exclude people in places of detention from receiving a medicine or pharmaceutical benefits available on the PBS if they have a valid Medicare card, receive treatment from a health professional with a PBS prescriber number, and a valid prescription is communicated to an approved PBS pharmacy. However, states and territories are responsible for the funding of medicines for people in places of detention, except for s100 Highly Specialised Drugs (HSD) medicines.³⁵ The Australian Government funds access for people in places of detention to s100 HSD medicines provided that the individual meets the PBS eligibility criteria.

In relation to s100 HSD medications and accessing the PBS, stakeholders reported several administrative issues and health workforce deficiencies that restrict access to these medications, including:

- Medicare card details are not routinely collected in places of detention and some individuals may not have a Medicare card or are unable to renew an expired Medicare card due to logistical/identity issues.
- Use of overseas-trained doctors who are restricted from receiving a Medicare provider number and therefore prescribing under the PBS for a period of ten years from the date of first medical registration unless they meet the requirements of s19AB or hold a s19AB exemption under the Health Insurance Act 1973.

³⁵ Australian Healthcare Associates, PBS Pharmaceuticals in Hospitals Review, 2019.

- Pharmacy location rules prevent the establishment of a pharmacy with a PBS approval number inside a facility as they need to be accessible by the public, limiting access to PBS benefits when inside a place of detention.
- Significant administrative burden for individuals seeking PBS reimbursement (complying with PBS restrictions and associated authority approval processes, sending the prescription to an approved hospital or community pharmacy, and transferring the medication to the place of detention for use).
- Dispensing and electronic medical records currently used in places of detention are not designed to use the Services Australia online PBS claiming system.

Supply and reimbursement of PBS benefits may only be provided by s90 approved pharmacies (community pharmacies) or s94 approved hospital pharmacies (which are subject to additional restrictions).

The review heard conflicting views regarding the consequences of the lack of PBS. Some stakeholders indicated that cost constraints have meant that places of detention may acquire cheaper substitutes for medication that may have significant side-effects or are not as effective, leading to poorer health outcomes. Other stakeholders stated that changed medications may be a result of shortages, specific preferences of service providers or the health literacy of prisoners, rather than being driven by cost imperatives. Lack of clear comparable data on these issues combined with a lack of clear health outcome measurement hinders a system level understanding of these issues.

Wait times significantly impact on accessibility and patient experience.

People in places of detention struggle to access health care in a timely manner.³⁶ This ranges from accessing GPs and primary health care nurses to organising specialist appointments and obtaining accommodation in specialist psychiatric facilities.³⁷ Certain health services are only available at set times and frequencies, meaning that individuals only have a small window of opportunity to access the service they need and often no way to ensure they can make that timeframe.³⁸ People in places of detention are also often unaware of their appointment times for security reasons, and the volatility of service provision and lockdowns means that appointments are shifted and cancelled on very short notice.³⁹ As mentioned above, there are also significant delays in accessing and transferring information between facilities and to the public health system due to the information systems not interfacing with each other. At times, individuals and their advocates must submit

³⁶ Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021.

³⁷ Coroners Court of Victoria, Inquest into the Passing of Veronica Nelson, 2023; Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021; PwC and Department of Health, Clinical Excellence Division, Offender Health Services Review, Queensland Government, 2018; S Kendall et al., Incarcerated Aboriginal women's experiences of accessing healthcare and the limitations of the 'equal treatment' principle, *International Journal for Equity in Health*, 2020, 19(48).

³⁸ NACCHO, Standards for Health Services in Australian Prisons: Submission to RACGP, NACCHO, 2022.

³⁹ Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021.

Freedom of Information (FOI)⁴⁰ requests for their own medical records – which further contributes to delays to accessing appropriate care.

2.3 Barriers to effective, culturally safe health care

Culturally safe health care is connected to family, community, Country and spirituality. Care that targets the whole person and is infused with First Nations people's ways of knowing and being.

Mainstream model of health care does not support a holistic approach to health and wellbeing.

The mainstream, Western model of health care provides the basis for custodial health service design and delivery across Australia. Health services and practitioners operating under this model are limited to practices, definitions and diagnoses that do not incorporate all the elements of "health" included under the First Nations model of social and emotional wellbeing. As a result, services and programs fail to recognise and meet all the requirements to achieve "good" health for First Nations people.

A culturally safe model of health care recognises the significant role that trauma plays in the social and emotional wellbeing of an individual, their family and community.

Trauma is not well understood by correctional and clinical staff.

People working in places of detention have limited understanding of trauma and how it can manifest across generations of First Nations families and communities. This has a significant impact on the way that First Nations people in places of detention are diagnosed and treated by staff and their peers.

Corrections staff and healthcare providers who lack awareness of the impacts of trauma may overlook or misinterpret the symptoms and needs of First Nations patients, leading to ineffective or inappropriate care. This misunderstanding often influences the way that certain behaviours are perceived (i.e. oppositional behaviours are viewed as defiant, rather than as a symptom of trauma), and the way that care is provided. Not only does this feed into systemic and interpersonal racism common in the correctional context, but it also often leads to the misdiagnosis and medication of individuals, causing further barriers for individuals to access the appropriate care and healing. Individuals experiencing trauma often have little understanding of the trauma itself and how it influences their actions and decision-making.

Culturally safety conflicts with the operational environment of places of detention.

The delivery of culturally safe health care in places of detention faces significant barriers due to the inherently traumatic nature of the corrections system itself. The custodial environment, characterised by confinement, surveillance, and loss of autonomy, can exacerbate existing traumas and limits the types of health care available to individuals, the times that they can access the care, and the timeliness of the care itself. Healthcare delivery within this context is constrained by priorities focused on security and control, rather than holistic wellbeing and cultural safety.

⁴⁰ Under the Freedom of Information Act 1982 (FOI Act)

Protocols in places of detention, such as isolation practices, further traumatise people rather than provide a pathway to rehabilitation, and improved health and wellbeing. In most facilities, medical information is shared with correctional staff who are involved in triaging health requests prior to accessing a medical practitioner. This process builds a distrust for the health services and can deter individuals from accessing the care that they need.

Individuals are not supported to maintain cultural connections and responsibilities in places of detention, increasing mental ill health and trauma. First Nations people are disconnected from family and their community through the security constraints and restricted communication with the outside world. Rather than providing a safe environment to rehabilitate vulnerable people, current custodial practices are contributing to the continued traumatisation of First Nations families and communities. This is particularly impactful for young people who enter places of detention, reinforcing generations of trauma caused by forcible removal of children from their families. Similarly, stakeholders reported the adverse effects on women with caring responsibilities when they are removed from their family units, primarily through their inability to connect to their children.

There are few programs that support cultural healing and recognise the impact of history on First Nations people's health.

The perception of people in places of detention lacks humanity; this is compounded by systemic racism against First Nations people

Societal and political perceptions of the people in places of detention fail to recognise it as a priority population, ignoring disproportionate social, economic and health challenges. For example, despite a national, whole-of-government commitment to Closing the Gap and addressing the overrepresentation of First Nations people in places of detention, this population is excluded from the general population when implementing national targets and strategies to improve health and social outcomes. This not only sets a precedent that deprioritises the need for quality and safe care for this population but also perpetuates the view that this is a group of people not worthy of the same level of care and humanity as the general population.

Informants to this review also noted the importance of language used to describe people in places of detention. There is a pervasive sense that these individuals are 'others', rather than 'family, mob, elders' or the traditional ways in which they are viewed by their community. Even those who are on remand and have not yet been sentenced for a crime, are viewed through the same lens.

While this invisibility may apply to the general population of people in places of detention, stakeholders reported that there is a specific disregard or lack of understanding of the role or responsibilities that First Nations people may have within their communities, and what the impact of this disconnection may be. The view that was shared with this review was that the punishment applied by places of detention was the removal of the individual from society, and that the broader system that enforces a blunt disconnect from a person's family, Country and community is rooted in a systemically racist view of First Nations people.

Maintaining continuity of care is a key challenge within places of detention.

People in places of detention are more susceptible to experiencing discontinuity of care as they are removed from the public health system. Incarcerated individuals' medical records are not linked to facility information systems and this places the burden of identifying existing health conditions on health assessments and the individual themselves.⁴¹ People in places of detention may not trust the staff or have the health literacy to appropriately communicate their diagnoses and needs – leading to sub-standard care or lack of treatment for chronic conditions.⁴²

Many facility information systems are not linked to one another, and some still use paper-based record-keeping. This means that when individuals transfer between facilities, there are often delays in transferring their medical records – resulting in repeated health assessments. This frustrates the individuals, drains resources, and takes staff away from providing treatment for health conditions.

Moving between custodial and community health services is also highly disruptive. Places of detention see their duty of care over the individual stop at the gate, leading to inadequate discharge planning and a lack of communication between custodial and community health services. As a result, people fall into the gap between the custodial and public health systems when they are at their most vulnerable.

Upon return to the community, many individuals struggle to access social supports such as housing, financial and unemployment support, disability services, and domestic and family violence services.⁴³ This social vulnerability is amplified by stigma and discrimination tied to their history of incarceration and impacts the likelihood of ex-prisoners seeking the appropriate health care that they require.⁴⁴

There is widespread stigma associated with accessing mental health and AOD services.

Stigma for people in places of detention with mental health and AOD needs reduce their likelihood of seeking therapeutic services throughout their sentence. This is fuelled by an understanding that an admission to this need will increase their vulnerability in places of detention, both amongst other individuals and the correctional system.

Stakeholders suggested that there is an unspoken understanding amongst people in places of detention, nation-wide, that the need to access mental health or AOD services reflects poorly on an individual by parole boards. As a result, people in places of detention avoid accessing therapeutic services out of fear of risking potential opportunities to be granted bail conditions or early release.

This stigma extends beyond places of detention and into the community where people are reluctant to access necessary services. An example raised through consultations was that First Nations women are less likely to access mental health and/or AOD services out of fear of being

⁴¹ AIHW, The health of people in Australia's prisons 2022, Australian Government, Canberra, 2023.

⁴² Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, 2021; PwC and Department of Health, Clinical Excellence Division, Offender Health Services Review, Queensland Government, 2018.

⁴³ AIHW, Improving mental health outcomes for Indigenous Australians in the criminal justice system, Australian Government, Canberra, 2021.

⁴⁴ AIHW, Improving mental health outcomes for Indigenous Australians in the criminal justice system, Australian Government, Canberra, 2021.

deemed a risk to their families, and consequently having their children removed from their care. The impact of this being not only on their immediate circumstances, but on the long-term wellbeing of the individual, families and communities.

Existing complaints mechanisms are not trusted to raise concerns or report breaches in human rights.

All states and territories have formal mechanisms through which people in places of detention and their families can lodge complaints, including state ombudsmen, independent visitors and legal aid organisations. Despite the availability of these avenues, stakeholders reported that there is a consistent distrust that their complaint will go anywhere, and in some cases that it may lead to negative consequences for the individual – particularly if the primary complaints line is internal or managed by corrective services.

Stakeholders also reported that people in places of detention experience additional barriers in making potential complaints. To lodge a complaint an individual must either use a phone, assuming they have the fund and privileges to do so, or submit a written complaint via the corrections officers, with no guarantee of privacy. There may also be significant wait times for access to legal aid services.

2.4 Opportunities for innovation and reform

Opportunities for innovation and reform were identified through the literature review, reported through stakeholder consultation, and then further refined through the roundtable meetings and with input from the project Advisory Group.

Nous' organisational architecture framework (Appendix E) has been used to arrange the identified opportunities and form the basis of the structure of recommendations presented in Section 3: Recommendations for reform.

A summary of opportunities identified through published literature are presented in Attachment 1: Literature Summary, and detailed discussion of the opportunities identified by stakeholders is presented in Attachment 2: Stakeholder Consultation Summary.

3 Recommendations for reform

This section outlines the recommendations for reform to improve the delivery of culturally safe health care to First Nations people in places of detention.

Six key recommendations for reform have been developed based on the findings of this review through the input of many stakeholders, a literature summary, and the counsel of a project Advisory Group. Eight overarching principles (Recommendation 1, page 27) have guided the development of recommendations. The recommendations are summarised overleaf with further detail provided in the following Section 3.

Although the scope of this review is to address health care for First Nations people in places of detention, the recommendations below relate to responsibilities beyond the portfolios of health ministers alone. Addressing First Nations health and wellbeing outcomes, particularly for those exposed to places of detention, requires ongoing investment and focus across many areas of government at the national, and state and territory level.

The recommendations in this review were developed considering the many recommendations that have come before, through various Royal Commissions and coronial inquests. The reviewers were conscious of these recommendations and existing efforts to improve the health, safety and wellbeing of First Nations people in places of detention. The reviewers developed the recommendations to complement and align with recommendations from the RCIADIC (Table 12, Appendix D), and minimise risks of detracting focus from important work already underway. This approach aims to create an environment in which the RCIADIC recommendations are addressed.

Table 2 | Summary of recommendations

Number	Recommendation description
1	Health and justice ministers agree to a set of national reform principles to drive action.
2	Health and justice ministers investigate evidence provided to the review and take steps to cease any practices that violence prisoners’ rights.
3	Establish a National Partnership Agreement to govern the reform of First Nations health services in places of detention
4	Implement a national program of work for First Nations health care in places of detention, led by the National Partnership Agreement The national program of work should address: <ul style="list-style-type: none">• National health outcome indicators• National First Nations model of care• Continuity of care• Innovative programs with proven success

Number	Recommendation description
	<ul style="list-style-type: none"> • National quality standards and reporting framework • Funding arrangements • Reporting and data collection • Workforce strategy • Infrastructure strategy and standards
5	Facilitate the leadership of Aboriginal community controlled health sector in the policy, design and delivery of health services in partnership
6	Health and justice ministers pilot alternative therapeutic models of custody for First Nations people, prioritising mothers and young people

3.1 **Recommendation 1: Health and justice ministers agree to a set of national reform principles to drive action**

Current state: Health care delivered in places of detention is the exclusive domain of each state and territory, and is governed differently in each jurisdiction.

Opportunity: Implementation of a set of principles co-designed with the Aboriginal community-controlled health sector would signal a clear commitment from all governments to a shared multilateral reform agenda.

An agreed set of principles will guide reform action.

Guiding principles, agreed by the health ministers and ministers responsible for corrective services in the Australian, state and territory governments, articulate a shared understanding of the goals and values driving any reform action to improve health care for First Nations people in places of detention. They align with what this review has heard is important to stakeholders. The application of these principles ensures consistency in policy development and supports transparency in decision-making.

A set of principles has been developed through this review.

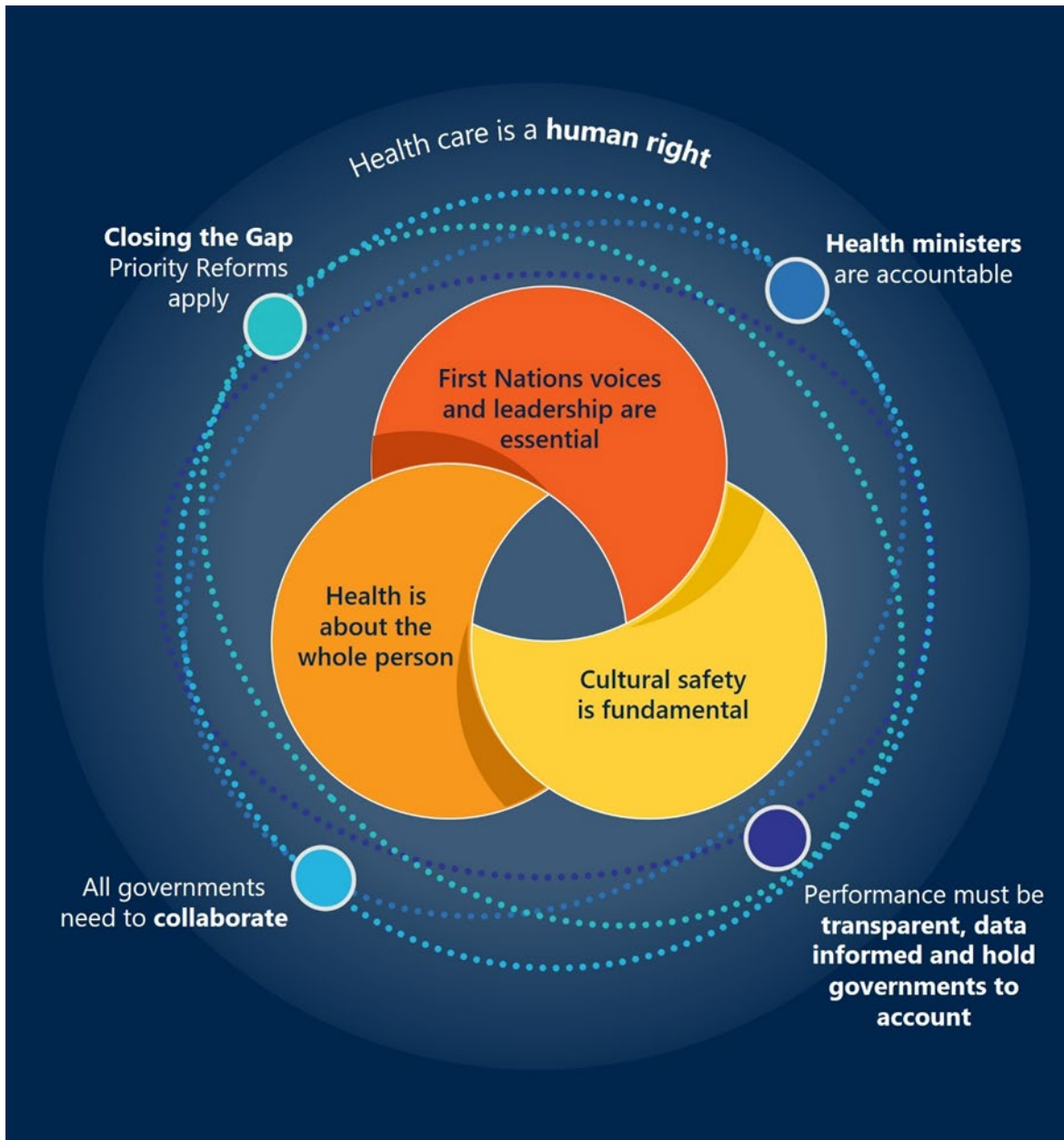
Nous developed a set of guiding principles informed by the Literature Summary and initial stakeholder consultations early in the review. Principles were presented and tested at each of the roundtable meetings in WA, ACT, NT and VIC, building and refining the set after each subsequent meeting.

The principles relate to various layers of governance, design and delivery of health care in places of detention for First Nations people. An overview of the principles is visualised in Figure 2 and more detail is provided below.

- **Cultural safety is fundamental. Health services must be culturally safe and delivered in a trauma-informed way.** A proactive and intentional approach must be taken to identify, challenge, and change the values, structures, and behaviours that perpetuate systemic racism within the custodial health system.

- **Closing the Gap Priority Reforms apply.** Places of detention are government services and are covered by the commitments and Priority Reforms of the Closing the Gap agreement. Closing the Gap targets cannot be met without addressing the health of the First Nations prison population.
- **First Nations voices and leadership are essential.** Self-determination must be central to the design, delivery and governance of health services. There should be First Nations leadership in the redesign of First Nations health services in places of detention and in service delivery to the best extent possible.
- **Health ministers are accountable.** Health care for all Australians should be the responsibility of health ministers, regardless of the setting in which it is delivered. Accountability for custodial health needs to be integrated with the broader health system, however its delivery within a place of detention should be independent from corrective services. This includes the choice of service provision by an ACCHO where feasible, to support continuity of care.
- **Health is about the whole person.** The definition of “health” is underpinned by the holistic principle of social and emotional well-being. Custodial health services must be proactive, person-centred and trauma-informed to enable improved health and social outcomes, noting that First Nations people in places of detention have ongoing cultural and spiritual connections to community and family.
- **Health care is a human right.** People in places of detention have the right to humane treatment and quality health care that meets their complexity of needs (under the Nelson Mandela Rules).
- **Performance must be transparent, data informed and hold governments to account.** Transparent performance monitoring and reporting against measurable targets ensures all governments can be held to account for progress.
- **All governments need to collaborate.** The Australian Government and state and territory governments share the responsibility of improving the way that health services for First Nations people in places of detention is governed, designed and delivered. Collaboration across governments and relevant portfolios is required for success.

Figure 2 | Principles to be agreed by health and justice ministers



3.2 Recommendation 2: Health and justice ministers investigate evidence provided to the review and take steps to cease any practices that violate prisoners' rights

Current state: Review informants shared evidence and examples of incidents of inhumane treatment. Case examples are also contained in recent coronial inquests and reviews. Stakeholders reported a series of extremely concerning practices leading to increased trauma and reduced health access.

Opportunity: Ceasing these practices would reduce trauma and improve mental health and care outcomes for current First Nations peoples in places of detention, their families and communities. Governments should identify and address practices that contravene Australia's human rights commitments and obligations.

Consistent with recent coronial inquests, evidence from stakeholder informants included some highly concerning and unacceptable practices relating to health care in places of detention across Australia. Due to the lack of national quantitative data, it was impossible to verify the extent of any practices, where, or how frequently they occurred. Nonetheless, the review team felt that it was important to reflect the evidence provided in keeping faith with the individuals and organisations who gave evidence to this review. In response, it is recommended that a process of jurisdictional review be undertaken, noting the existing oversight mechanisms, to ensure that where and if these practices do exist, they are identified, reported on and immediately ceased. It should be noted that previous reports and coronial inquests also identify unacceptable practices linked to specific adverse events.

These practices not only have significant impacts on physical, mental, social and emotional health, but directly oppose the rights of people in places of detention under internationally agreed standards. This review has used the United Nations Standard Minimum Rules for the Treatment of Prisoners ('Mandela Rules')⁴⁵ as an illustration of how current reported practices may contravene these international standards. The review team recognises that there are a range of other international treaties and obligations that Australia is party to, however this review has not been the place for a comprehensive assessment of these requirements. Table 3 overleaf summarises the examples of current practices that stakeholders reported through this review that contravene the Mandela Rules.

The examples provided to this review are not assumed as standard across all places of detention but were reported through the consultation process by stakeholders who operate in various places of detention or work directly with people with lived experience in such facilities. Reports were either first-hand accounts or second-hand retellings from people who have witnessed these practices

⁴⁵ United Nations Standard Minimum Rules for the Treatment of Prisoners are a non-binding UN Resolution that are intended to provide interpretative guidance to Member States (not a treaty). The rules should be read in conjunction with the text of the relevant treaties and other interpretative material, such as the General Comments of treaty bodies, and are designed to be adapted to local circumstances by Member States.

occur. This list does not fully account for all possible breaches of Australia's human rights obligations but reflects what was shared through the review process.

International normative standards and human rights obligations

Australia is a signatory to several international human rights treaties that outline minimum standards to protect the rights of individuals in places of detention, including their right to healthcare services. The United Nations Standard Minimum Rules for the Treatment of Prisoners ('Mandela Rules') serve as an international guide that enshrines the right of people in places of detention to have a provision of care equivalent to that available in the community.⁴⁶

Australia is party to seven core international human rights treaties – most relevantly, Optional Protocol to the Convention Against Torture (OPCAT, see below) and these treaties are implemented into the Australian domestic legal framework in a variety of ways. Australia has obligations to uphold human rights under CAT⁴⁷, ICCPR⁴⁸, ICESCR⁴⁹, CEDAW⁵⁰, CRC⁵¹, CERD⁵², and CRPD⁵³. Each of these treaties include human rights that may extend to places of detention. Australia has not enacted federal legislation that incorporates these treaties, however Victoria, Queensland and the ACT have human rights legislation in place that outlines the right of prisoners to protect their dignity, including the right to receive adequate health care and medical treatment while in custody.⁵⁴ State corrections agencies have also endorsed national (non-enforceable) guiding principles for custodial facilities, which affirm the need for equivalence of care.⁵⁵

Progress Australia's obligations under the Optional Protocol to the Convention Against Torture (OPCAT)

In 2017 Australia ratified the Optional Protocol to the Convention Against Torture (OPCAT), requiring every state and territory to have designated a 'National Preventive Mechanism' to carry out inspections and oversight of police and prison cells (as well as other places of detention) to protect against torture, mistreatment, abuse and systemic failings. This review recognises that there is significant work happening across jurisdictions to legislate these mechanisms, and that there is a future opportunity to utilise these mechanisms to support this recommendation.

Across the health system, at both the national and jurisdictional levels, there are mechanisms through which complaints can be lodged by patients, their families and advocates, as well as independent bodies that respond to reported adverse events. Within the aged care system, it is

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⁴⁸ International Covenant on Civil and Political Rights

⁴⁹ International Covenant on Economic, Social and Cultural Rights

⁵⁰ Convention on the Elimination of All Forms of Discrimination Against Women

⁵¹ Convention on the Rights of the Child

⁵² International Convention on the Elimination of All Forms of Racial Discrimination

⁵³ Convention on the Rights of Persons with Disabilities

⁵⁴ Charter of Human Rights and Responsibilities 2006 (Vic); Human Rights Act 2019 (Qld); Human Rights Act 2004 (ACT); *Castles v Secretary to the Department of Justice* [2010] VSC 310.

⁵⁵ Guiding Principles for Corrections in Australia.

additionally mandated that any adverse events are reported to the national regulator. For health services delivered within places of detention, there are also various mechanisms in place to lodge complaints, including State and Territory Ombudsman Offices, other bodies such as the NSW Health Care Complaints Commission; the Victorian Office of the Health Services Commissioner or the Health and Disability Services Complaints Office in WA; and the state and territory human rights commission or Australian Human Rights Commission. However, it was consistently reported to this review that these mechanisms are not accessible to people in places of detention, or they are not utilised due to fear of repercussions. It is important that reform to improve access to complaints arrangements create that accessibility pathway to enable access and use of meaningful complaints processes by people in the system, without fear of repercussions.

The review notes that there a range of existing oversight mechanisms for services delivered in places of detention, however found limited evidence of their presence in discussions about current practice considered demeaning and inhumane by informants. The identification of these issues through these existing mechanisms seems unlikely without a specific focus and reporting requirement. State and territory governments should immediately work to proactively identify and cease any practices that violate the rights of people in places of detention. It is essential that this process and subsequent action is done with transparency and the inclusion of First Nations leadership. The results of this work should then be reported back to the Ministers for Health and Justice and verified by an appropriate independent mechanism – such as state ombudsmen or OPCAT, when in place.

This review recommends that urgent action be taken to ensure that Australian is compliant with obligations to protect the humanity, dignity and health of First Nations people in places of detention.

Table 3 | Current reported practices in violation of the Mandela Rule

Example of current practices	Corresponding Mandela Rule in violation ⁵⁶
Women handcuffed during childbirth	Rule 48 2. Instruments of restraint shall never be used on women during labour, during childbirth and immediately after childbirth.
Children immediately removed from mothers at birth	Rule 29 1. A decision to allow a child to stay with his or her parent in prison shall be based on the best interests of the child concerned. Where children are allowed to remain in prison with a parent, provision shall be made for: (a) Internal or external childcare facilities staffed by qualified persons, where the children shall be placed when they are not in the care of their parent;

⁵⁶ United Nations Standard Minimum Rules for the Treatment of Prisoners.

Example of current practices	Corresponding Mandela Rule in violation ⁵⁶
	<p>(b) Child-specific health-care services, including health screenings upon admission and ongoing monitoring of their development by specialists.</p> <p>2. Children in prison with a parent shall never be treated as prisoners.</p>
Lack of complaints processes for prisoners	<p>Rule 56</p> <p>1. Every prisoner shall have the opportunity each day to make requests or complaints to the prison director or the prison staff member authorized to represent him or her.</p> <p>2. It shall be possible to make requests or complaints to the inspector of prisons during his or her inspections. The prisoner shall have the opportunity to talk to the inspector or any other inspecting officer freely and in full confidentiality, without the director or other members of the staff being present.</p> <p>3. Every prisoner shall be allowed to make a request or complaint regarding his or her treatment, without censorship as to substance, to the central prison administration and to the judicial or other competent authorities, including those vested with reviewing or remedial power.</p>
Restricted accessibility of drug and alcohol dependence treatment programs	<p>Rule 24</p> <p>2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.</p>
Strip searches of female prisoners by male staff	<p>Rule 52</p> <p>1. Intrusive searches, including strip and body cavity searches, should be undertaken only if absolutely necessary. Prison administrations shall be encouraged to develop and use appropriate alternatives to intrusive searches. Intrusive searches shall be conducted in private and by trained staff of the same sex as the prisoner.</p>
Punishment for behaviour related to mental illness or intellectual disability (where medication has not been provided)	<p>Rule 39</p> <p>3. Before imposing disciplinary sanctions, prison administrations shall consider whether and how a prisoner's mental illness or developmental disability may have contributed to his or her conduct and the commission of the offence or act underlying the disciplinary</p>

Example of current practices	Corresponding Mandela Rule in violation ⁵⁶
	charge. Prison administrations shall not sanction any conduct of a prisoner that is considered to be the direct result of his or her mental illness or intellectual disability.
Lack of appropriate disability support	<p>Rule 5</p> <p>2. Prison administrations shall make all reasonable accommodation and adjustments to ensure that prisoners with physical, mental or other disabilities have full and effective access to prison life on an equitable basis.</p>

3.3 Recommendation 3: Establish a National Partnership Agreement to govern the reform of First Nations health services in places of detention

Current state: Health care delivered in places of detention is the exclusive domain of each state and territory, and is governed differently in each jurisdiction.

Opportunity: Implementation of a set of principles co-designed with the Aboriginal community-controlled health sector would signal a clear commitment from all governments to a shared multilateral reform agenda.

A National Partnership Agreement to improve First Nations health services in places of detention will bring together resources, expertise, and knowledge from government agencies and community organisations sectors to tackle the systemic issues surfaced in this review.

The National Partnership Agreement would be a mechanism that drives shared responsibility, accountability, and ownership of initiatives to improve health outcomes for First Nations people within places of detention. It would establish governance and document the commitment and contribution of the Australian Government and each state and territory government. Further details of the National Partnership Agreement are outlined in Table 4.

This review also recognises that a program of work under the National Partnership Agreement would focus on health but exist within the broader justice system. This provides opportunities to create linkages with work being led by justice, for example the establishment of legislation under OPCAT.

A National Partnership Agreement must align with the Priority Reforms outlined in the National Agreement on Closing the Gap.

The proposed National Partnership Agreement will drive progress towards Closing the Gap through alignment with several Priority Reforms:

- **Priority Reform 1: Partnership and Shared Decision-Making:** the National Partnership Agreement would ensure that First Nations leaders and communities are represented through

genuine partnership and leadership within the agreement mechanism, driving the design and implementation of the national program of work.

- **Priority Reform 2: Building the Community-Controlled Sector:** the National Partnership Agreement would directly support the involvement of ACCHOs, drawing on their knowledge and expertise to design a national program of work that meets the needs of First Nations people in places of detention. The Agreement should also provide the appropriate resourcing to fund and strengthen these services.
- **Priority Reform 3: Transforming Government Organisations:** a key element of the National Partnership Agreement will be to implement reforms that improve the transparency and accountability of governments in the delivery of health care to First Nations people in places of detention, driving system-level change for government organisations to become more culturally competent and responsive to the needs of this population.

The review found that a coordinated, national approach is needed to drive reform action for First Nations health care in places of detention.

Stakeholders consistently reported that there is a need for improved national coordination to design and lead reform for health care delivery in places of detention. As outlined below in Recommendation 4, this could include the mandate to develop a national strategy for First Nations health care in places of detention and a set of national minimum service standards. The establishment of a National Partnership Agreement will provide:

- **Consistency.** There is significant jurisdictional variation in how healthcare services are currently being delivered to First Nations people in places of detention. A National Partnership Agreement with a clear mandate to deliver a national justice health strategy and establish national health service standards would provide consistency not only in how healthcare services are being delivered, but also in how they are being monitored and assessed.
- **Accountability.** Commitment from the Australian and state and territory governments to implement a national strategy and adhere to national standards, including reporting against key performance indicators (KPIs), would establish clear accountability for continuous improvement.
- **Transparency.** The Agreement should facilitate oversight of the monitoring and reporting of the performance of jurisdictions or facilities and support data sharing between government and community organisations. This would build trust across the sector and support informed decision-making by policymakers, healthcare providers, and the community.
- **Leadership.** Stakeholders noted that a lack of existing leadership in this space has meant that any progress or attention has been driven by a smaller number of highly engaged individuals. A formal partnership agreement would provide a mechanism for longer-term leadership and ensure ongoing First Nations representation and advice.
- **Improved quality of service delivery.** Transparent data sharing would facilitate quality improvement efforts within custodial health services. By openly sharing data on healthcare outcomes, patient experiences, and performance indicators, custodial healthcare providers can identify areas for improvement and implement evidence-based practices to enhance the quality and safety of care.

States and territories will have specific actions to enable the national program of work.

To deliver on the national program of work, there will be specific actions that are the responsibility of state and territory governments. These are outlined below. This would be complemented by Australian Government commitment to a national program of work, coordination and the contribution of structural changes to Medicare to support continuity of care.

Implementing the recommendations of this review and achieving the outcomes of the National Partnership Agreement for Closing the Gap and the RCIADIC requires commitment from the states and territories.

States and territories must engage in the following actions:

1. **Agree to adopt the national reform principles.** The states and territories must adopt the principles and report on what mechanisms they have implemented to entrench the principles in their strategies, policies and operations.
2. **Sign up to the national program of work.** Through their partnership membership, the states and territories must support the design and implementation of the program of work and join in the national coordinated approach.
3. **Establish state level formal partnerships.** States and territories must embed First Nations leadership in their governance, setting up arrangements between health departments, justice departments and NACCHO affiliates to oversee and implement the program of work at a state level.
4. **Agree to national health standards for places of detention.** States and territories must commit to entrenching the standards into their corrections systems, policies and procedures.
5. **Agree to the provision of information and data.** States and territories must provide information and data on health outcomes, adherence to standards, funding, workforce and infrastructure. This can occur through third parties such as the AIHW.
6. **Implement state workforce strategy.** To ensure a pipeline of capable workforce (both Indigenous and non-Indigenous), states and territories could establish strategies to attract talent, retain skilled workers, and address workforce disparities to improve health outcomes. This should be considered in the context of other national workforce strategies.
7. **Implement state infrastructure strategy.** Assess current state of health infrastructure in places of detention and allocate capital funding to improve facilities to support better health outcomes. Work with local Aboriginal community controlled organisations to design fit-for-purpose and culturally safe health facilities.

Oversight and accountability of healthcare services within places of detention would be managed through existing mechanisms.

The mainstream healthcare system has several mechanisms by which it oversees the quality and safety of services at the national, and state and territory levels. These include the national standards, guidelines, and accreditation processes developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC), funding models developed by the Independent Hospital Pricing Authority (IHPA), and the audits and accreditation assessments of healthcare facilities, services, and practitioners to ensure compliance with standards, regulations, and best practices.

Rather than establishing a parallel oversight system or body, there is opportunity for better integration of custodial healthcare services with these mechanisms, bringing the custodial health system into alignment with the mainstream healthcare system.

Table 4 | Key elements of a National Partnership Agreement

Parties involved	<ul style="list-style-type: none">• Australian, state and territory health and justice ministers• Aboriginal and Torres Strait Islander leaders
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Scope and purpose	<p>The National Partnership Agreement would outline the contributions and expectations of each jurisdiction in delivering the national program of work.</p> <p>It is a mechanism to develop a joint approach to First Nations justice health policy, with a focus on improving health outcomes for adults and young people in places of detention.</p> <p>The National Partnership Agreement would also outline clear reporting arrangements with mechanisms to share data across jurisdictions.</p>
Objectives	<ul style="list-style-type: none"> • Establish a shared vision and approach to improve the health outcomes of First Nations adults and youth in places of detention based on the agreed principles. • Embed the CtG Priority Reforms to effect sustainable improvements in the health of First Nations people in places of detention. • Oversee a national program of work as detailed below.
Duration	5 years
Public awareness and transparency	The National Partnership Agreement would be published and made publicly available through the National Partnership.
Funding	<p>The National Partnership Agreement requires adequate resourcing to fully realise its purpose and would include a condition for the maintenance of effort for health expenditure in places of detention.</p> <p>The Australian, state and territory governments must commit and be held accountable for ensuring that there are appropriate levels of funding to drive improved health outcomes for First Nations people in custody. Alternatively, a separate block funding arrangement could be entered into through a schedule in the National Hospital Reform Agreement to support state and territory-led health care.</p>
Delivery	<ul style="list-style-type: none"> • Oversee and resource a national program of work, including: <ul style="list-style-type: none"> • Establishing an agreed set of health outcome indicators for First Nations people in places of detention. • Developing a national First Nations model of care for health care that is fit-for-purpose and can be tailored to a local context. • Strengthening continuity of care for people moving through the custodial system. <ul style="list-style-type: none"> • Documenting and evaluating therapeutic programs and expand and replicate those with proven success. • Agreeing a set of national quality standards for the delivery of culturally safe health care to First Nations people in places of detention.

	<ul style="list-style-type: none"> • Establishing funding arrangements that enable design and delivery of enhanced healthcare services according to need. • Establishing reporting and data collection processes for outcomes, services delivered, compliance with national quality standards and funding committed. • Developing a national prison health workforce strategy to support the delivery of culturally safe health care. • Developing an infrastructure strategy to support the delivery of culturally safe health care.
Monitoring and reporting	<p>A National Partnership Agreement would establish responsibility for monitoring and reporting on the outcomes in the National Strategy, as well as the performance of the national program of work across each jurisdiction.</p> <p>Annual reports will be submitted to the Minister for Health and made publicly available.</p>

3.4 **Recommendation 4: Implement a national program of work for First Nations health care in places of detention, led by the National Partnership Agreement**

Current state: There are significant multi-faceted barriers that need to be addressed to ensure delivery of effective and culturally safe health care for First Nations people in places of detention.

Opportunity: The development of a national program of work that proactively addresses barriers and responds to a system that produces racist outcomes for First Nations people.

The National Partnership Agreement will govern a national program of work based on priority reform opportunities identified in this review. The program of work will consist of national coordinated action as well as specific commitments from the states and territories. The national program of work should address:

- National health outcome indicators
- National First Nations model of care
- Continuity of care
- Innovative programs with proven success
- National quality standards and reporting framework
- Funding arrangements
- Reporting and data collection
- Workforce strategy

- Infrastructure strategy and standards.

3.4.1 Establish an agreed set of health outcome indicators for First Nations people in places of detention

The national program of work should include the development of an agreed set of expected health outcome indicators for First Nations people in places of detention, to promote equity in health care access, strengthen monitoring and accountability, and support quality improvement of health services. National health outcome indicators that are culturally informed and responsive to the needs of First Nations people would promote cultural safety within custodial healthcare settings. Appropriate health outcome indicators for First Nations people currently exist in mainstream healthcare systems and should be combined and adapted for places of detention. These include:

- The Core Services and Outcomes Framework that guide ACCHOs to deliver a comprehensive primary healthcare service.
- Population screening targets.
- Immunisation targets.
- Access to mental health assessments and follow up treatment.

National health outcome indicators would be accompanied by performance targets, and could include the following domains:

- **Access to preventative care** – regular health check-ups, immunisations, screenings for chronic diseases, and health education programs promoting healthy lifestyle behaviours.
- **Detection and management of chronic conditions** – early detection and management of chronic diseases such as diabetes, hypertension, and respiratory conditions through comprehensive primary healthcare assessments, monitoring, and culturally safe treatment plans
- **Mental health and AOD support** – integrate mental health and AOD treatment and support services into primary health care delivery for First Nations people in places of detention, ensuring timely access to culturally appropriate assessments, counselling, therapy, and rehabilitation programs to support recovery and wellbeing.
- **Pre- and post-natal support** – pre-natal care delivered, screening for risk factors, birth outcomes including rates of preterm birth, low birth weight, and neonatal complications, postpartum care.
- **Screening of cognitive disabilities and neurodevelopmental conditions such as FASD** – screening upon entry with links to assessment and therapeutic supports.
- **Dental care** – oral health status, access to dental care, treatment outcomes, prevention and dental hygiene education.
- **Health literacy and self-management support** – supporting First Nations prisoners to actively participate in their own health care by providing information, resources, to support self-determination.

Diabetes support and treatment for First Nations people in places of detention

Diabetes, particularly type 2 diabetes, is a significant health issue among First Nations Australians. This problem is exacerbated in places of detention, where the prevalence of diabetes is often higher compared to the general population. This review heard several accounts of the challenges faced by individuals with diabetes in accessing medication, adequate nutrition options and support with everyday disease management.

Early detection and management of diabetes is essential to reducing health disparities for First Nations people and improving overall health outcomes.

3.4.2 Develop a national First Nations model of care that is fit-for-purpose and can be tailored to a local context

A national model of care that can be delivered to all First Nations people in places of detention needs to be fit-for-purpose and provide culturally appropriate health services to support improved health outcomes. The national program of work should include the design and implementation of a model of care that is in alignment with the NACCHO core services model, adaptable to any facility, and able to be implemented by either a government health service or an ACCHO. While the model of care should provide consistency in the types of care delivered in places of detention across Australia, it should enable flexibility for tailoring to suit local contexts, service availability and needs.

At a local level, the model of care should be actively tested and tailored through engagement with the Aboriginal community-controlled health sector and local First Nations communities to respond to local needs and leans on trusted, local resources (e.g. ACCHOs) where possible. This includes the identification of appropriate service delivery partners. All services should review policies and procedures to identify where they conflict with the model of care and implement changes to remedy these.

The national model also needs to be adaptable to reflect the varying complex needs across different sub-population groups. In consultations, stakeholders highlighted the nuances of delivering health care to young people, women, people living with addiction and people with disabilities in places of detention. Central to each model of care should be the principles of holistic health and social and emotional wellbeing outlined in Recommendation 1.

A model of care should also reflect the specific considerations for young people, women, people living with addiction, and people with disabilities, outlined in Table 5 below.

Table 5 | Considerations for a model of care

Population group	Considerations
Young people	<ul style="list-style-type: none"> • A model of care should reflect the disproportionately high rates of FASD and other neurodevelopmental conditions among young people in detention. Correctional and health staff need to be appropriately trained to recognise certain behaviours as clinical symptoms, instead of acts of defiance. • There is opportunity for improved diagnosis for young people with disabilities in the prison system to support them to prevent recidivism after their release. • Young people are often taken off-site to external outpatient or emergency services, where their health needs are reportedly taken less seriously than the general population, even where there was risk of self-harm. • Stakeholders reflected that the most successful youth detention facilities viewed themselves more as a boarding school than a prison. Instead of being driven by security measures, these facilities are led by values of education, employment and social wellbeing.
Women	<ul style="list-style-type: none"> • Women in prisons typically have more complex mental health and trauma-related needs than men, requiring longer appointments and more follow-up. These women often experience significant trauma, exposure to family violence and removal from children. • Pregnant women require specific care, particularly those in late gestational stages who may have co-occurring conditions which complicate the care that they require. • Ideally, women should have the option to see a female clinician where possible, noting that the corrections environment is very male dominated.
People living with addiction	<ul style="list-style-type: none"> • Stigma surrounding alcohol and drug dependencies is a significant issue in places of detention, despite this population being overrepresented in the corrections system. • A model of care should focus on harm minimisation approaches to addressing substance use, rather than the prohibitive mode that is currently adopted in Australian prisons. <ul style="list-style-type: none"> • There are severely high rates of Hepatitis C, other blood-borne viruses (BBVs) and bacterial infections that need to be addressed. First Nations people are disproportionately represented in these numbers and a model of care should look at innovative ways to

	<p>adapt harm minimisation protocols (e.g. needle exchange programs) in places of detention.</p> <ul style="list-style-type: none"> Stakeholders highlighted that illicit drugs can be easier to access within places of detention than in the community. Given the prohibition of any substances, people are not supported in taking the necessary precautions to protect against additional harm i.e. BBV infections.
People living with disabilities	<ul style="list-style-type: none"> A model of care for health in places of detention should include disability care, given the disproportionately high rates of disability (diagnosed and undiagnosed) in the correctional system, particularly for First Nations people. It is essential that people who require disability care are well supported within places of detention, and even more so at points of transitions so they can be connected with disability supports in the community upon release. This will support overall social and emotional wellbeing, and ultimately reduce the risk of recidivism in later stages.

3.4.3 Strengthen continuity of care for people moving through the custodial system

The national program of work should support continuity of care for people moving in and out of the custodial system. People leaving places of detention are at their most vulnerable upon release back into the community. To address this, there should be a focus on arranging improved throughcare services for people transitioning back into the community and better integration with community health and other services upon release. This may include community based holistic case management models (including long-term and options to opt in and out) to strengthen service connections and effectively disrupt the pathways that lead to recidivism. In particular, there should be support for individuals to obtain a Medicare card, a key gateway to accessing health assessments, essential medications, alcohol and drug programs, and chronic health care. Stakeholders informed the review that the best health outcomes occur when there are strong connections between service delivery and the person's community and culture. Throughcare programs can be delivered by ACCHOs (e.g. Waminda, NSW) or non-Indigenous organisations which often have a tailored program specific to First Nations people in places of detention (e.g. Outcare, WA).

Continuity of care also extends to individuals who are on remand. This review heard that remand is a time of vulnerability for many individuals who do not have access to either external mainstream services or the custodial health services delivered in other settings. There should be particular attention to supporting First Nations people on remand by reviewing their eligibility for treatment and throughcare programs, and ensuring they have appropriate discharge planning and connection

with community services. This may also include capturing data on suicides post-release as part of the minimum data set discussed below.

Effective continuity of care should also involve connecting electronic medical record systems between different custodial health providers and public/community health providers. It is essential that this is done with the appropriate consent from the person in custody. This would ensure that previous diagnoses and outstanding health conditions are known and can be addressed in custody and on transfer between facilities. Similarly on release, conditions identified and treated in a place of detention can continue to be managed once the person returns to the community. This would improve continuity of care and reduce the time and cost of health assessments, allowing for greater resources for treatment of conditions.

3.4.4 Document and evaluate therapeutic health programs and expand and replicate those with proven success

Health ministers should commit to the evaluation and expansion of existing programs that are delivering innovative, therapeutic models either within places of detention, or in the community and have the potential for adaptation to the custodial system context.

Stakeholders highlighted significant opportunity to expand programs particularly related to spiritual healing, health literacy and harm minimisation for people who inject drugs (PWID). Spiritual healing and health literacy programs currently exist in limited capacity across Australia and were raised through this review as an essential tool to support the social and emotional wellbeing of First Nations people while in places of detention and upon re-entry to the community. Harm minimisation protocols for PWID, such as needle exchange programs, are not currently available in Australian places of detention but have had success in reducing transmission of Hepatitis C and other blood-borne viruses (BBVs) in community-based programs. More detail on these types of programs is provided below.

- **Spiritual healing** offers an opportunity for First Nations people in places of detention to understand their individual trauma, pathways to healing, and connect with their spiritual and cultural identity. The Healing Foundation (national) and Marumali (VIC) deliver evidence-based programs to adults, young people and staff across the justice system, including within places of detention, to provide education on the intergenerational impacts of forcible removal of Stolen Generations. Shine for Kids (national) focuses on supporting children impacted by the incarceration of their parents, aiming to maintain connections between children and parents through various programs and minimise the impact of forced separation. These programs shine a light on how trauma can manifest in varying ways for First Nations people in places of detention and give people tools to support their journey to social and emotional wellbeing.
- **Health literacy and education** programs are regularly delivered in the community to priority populations, including First Nations groups, to empower individuals to seek proactive health care and educate them to make informed decisions regarding their care. These programs should be adopted into places of detention to support people in custody and correctional staff who are often a gateway for accessing health services in prisons. Programs that target specific disease groups that are disproportionately common in prisons should also be investigated for

expansion across the corrections system. The National Prisons Hepatitis Education Program (HepPEd Program) delivered a comprehensive suite of educational resources to healthcare providers, correctional officers and people in custody to address key barriers to understanding and addressing Hepatitis C in prisons.⁵⁷

- **Harm minimisation** programs for PWID will help to address the disproportionate rates of BBVs and other infections transmitted through unsafe needle and syringe sharing, as they currently do in the community. Stakeholders raised challenges in the increasing transmission of Hepatitis C, suggesting that current prohibitive approaches to drug use is ineffective. Countries such as Germany, Spain and Switzerland have reported successful outcomes from delivering adapted needle exchange programs in prisons over several decades.⁵⁸ There is opportunity to learn from these programs to identify strengths and opportunities for better adaptation to the Australian custodial health landscape.

3.4.5 Agree a set of national quality standards for the delivery of culturally safe health care to First Nations people in custody

There are currently no national quality standards for the delivery of health care in places of detention, let alone an agreed national standard of culturally safe care for First Nations people in custody. The national program of work should include the development and implementation of a set of national standards for the provision and monitoring of health care in places of detention to ensure an optimal standard of care is available to all incarcerated individuals, regardless of their location or specific facility.

National quality standards would also provide a framework for assessing and monitoring the quality of healthcare delivery at the facility level. This standardisation of care could also facilitate better information sharing across facilities and jurisdictions, healthcare providers and community organisations, supporting a more integrated and efficient healthcare system within places of detention.

Adherence to national standards would also enhance transparency and accountability, as it allows for greater scrutiny of healthcare practices in places of detention and enables stakeholders to hold authorities accountable for meeting established benchmarks.

Provisions could relate to:

- Health care quality and safety.
- Culturally safe and trauma-informed services/workforces/processes.
- Funding to specific services and program types.

⁵⁷ Sheehan, Byrne, Dawson, Stewart, Lever, Habraken, Tedla, Lafferty, Lloyd. National prisons Hepatitis education program (HepPEd Program): an evidence-based Hepatitis C education to enhance public health literacy in the Australian prison sector. International Network on Health and Hepatitis in Substance Users. 2022.

⁵⁸ National Drug and Alcohol Research Centre (NDARC), University of New South Wales. Prison-based syringe exchange: a review of international research and program development. Sydney, 2001.

- Information sharing between agencies.
- Continuous quality improvement within custodial healthcare services.

The national quality standards could be based on the RACGP standards for health services in Australian prisons and NACCHO's associated standards and recommendations, NSQHS standards relating to First Nations health and cultural safety, and AHPRA registration standards and codes relating to cultural safety.

National standards should be for the provision of optimal care, not minimum care

This review notes that the existing standards referenced in this report (e.g. Mandela Rules) are the minimum requirements for the treatment of people in places of detention. Similarly, the language heard from some stakeholders when describing their desired outcome for the reform of custodial health for First Nations people was for facilities 'to meet a minimum standard of care'.

It is recommended that in the development of a set of national quality standards for First Nations health care in places of detention, there is a focus on reaching optimal care for this population, not just minimum care. In the same way that aspirational health strategies are developed with the aim to deliver the best health outcomes possible for the Australian population, so too should reform in this space be aspirational for a population that is so often invisible to the rest of the system.

3.4.6 Establish funding arrangements that enable design and delivery of enhanced healthcare services according to need

States and territories are operators of custodial systems and responsible for the quality and delivery of healthcare services in that context. This is consistent with the legislative requirements for custodial healthcare delivery and should remain as the primary funding arrangement for these services.

The Australian, state and territory governments must commit and be held accountable in ensuring that there are appropriate levels of funding to drive improved health outcomes for First Nations people in places of detention. Many jurisdictions use the concept of equivalence to community access as the test for the appropriate level of care. Stakeholders informing this review argued this test is a minimum and not calibrated to the increased levels of health care need of those in places of detention. A needs-based health care model with comprehensive assessment and follow up care should be funded according to level of care required, recognising this will be greater than the level of health care provided in the community in many cases.

However, this review does recommend changes to the availability of a set of Medicare funded services, where these services connect the care of those in places of detention with the rest of the healthcare system. A funding structure that maximises the opportunity to ensure continuity of care across the health/custodial barrier will improve continuity of care and reduce the need for multiple assessments.

This review also recommends that healthcare expenditure and funding arrangements become more transparent to allow for a better understanding of the current investment levels and their overall

adequacy. In combination with other elements of the national program of work, this will allow benchmarking and clearer understanding of the relationship of current funding levels to achieved health service access and outcomes.

Explore options to access Medicare and Medicare Benefits Schedule.

To bridge the disconnect between Medicare and the corrections system, the Australian Government should explore limited activation of MBS in places of detention through an s19(2) exemption with conditions. Tailored MBS items may be developed that 'mirror' general MBS items, allowing for transparent tracking of healthcare service use in places of detention. The items could focus on connecting general practitioners into the system – such as through the provision of culturally appropriate assessments and health checks, telehealth, mental health plans, GP chronic care planning and review, multi-disciplinary case conferences and post-release GP care.

Specific items that could be mirrored include:⁵⁹

- Item 715: assessment and health checks for Aboriginal and Torres Strait Islander people.
- Item 10987: Follow-up by practice nurse or Aboriginal health practitioner.
- Items 81300-81360: Follow-up allied health services for Aboriginal people.
- Item 735-738: Multi-disciplinary case conferences for people with chronic conditions.
- Items 701-707: Supporting GPs to undertake post-release care.

Having mirrored MBS items for states and territories to use for their custodial health services would provide a clear picture of the volume of MBS usage in places of detention.

There are additional considerations that will need to be addressed to appropriately implement the MBS exemption including ensuring patient and practitioners are Medicare eligible, and that Medicare details are captured on entry. If Medicare cards have expired, a streamlined approach to validating identities and providing renewed Medicare cards should be developed with Services Australia. Consideration should also be had for non-citizens who may be eligible for Medicare but whose visa has been cancelled. Practitioners (such as overseas-trained doctors) who may be restricted from receiving a Medicare provider number should be supported to do so under the Health Insurance Act 1973.

This review has found that providing a blanket exemption for custodial health services to utilise MBS will not lead to overall health service improvements nor necessarily address workforce shortages. It has the potential to increase fragmentation of service delivery and not lead to additional care. MBS has been extended to other care settings, such as the residential aged care sector, which did not lead to the desired outcomes as general practitioners were not motivated to provide care in those settings. As in residential aged care,⁶⁰ there would need to be considerations

⁵⁹ Inspector of Custodial Services, Health services in NSW correctional facilities, NSW Government, March 2021; TM Plueckhahn, SA Kinner, G Sutherland, TG Butler, Are some more equal than others? Challenging the basis for prisoners' exclusion from Medicare, Medical Journal of Australia, 2015; 203 (9): 359-361; RACGP, Submission on Access to Medicare in Prison, 2017.

⁶⁰ Department of Health and Aged Care, New Arrangements for GP Residential Aged Care Facility (RACF) services, Australian Government, 2019.

of how to incentivise GPs to attend places of detention – especially when they would have to spend time travelling to and accessing facilities, deal with difficult environments and manage lockdowns.

Negotiate arrangements with states and territories for access to the Pharmaceutical Benefits Scheme in places of detention.

There is no legislative barrier to the use of the Pharmaceutical Benefits Scheme for people in places of detention. If individuals have access to a valid Medicare card, there are no eligibility issues in accessing the PBS. However, Australian Government funding for the PBS is limited to \$100 HSD medications, and not to \$85 general supply medications.

There may be whole-of-system savings if the states and territories can access the reduced purchase prices that the Australian Government can achieve through its Pharmaceutical Benefits Scheme. The Australian Government negotiates with pharmaceutical companies on price settings and can leverage the scale of the PBS to achieve cost savings.⁶¹

To access a broader series of medications, there could be consideration of a range of different models, including:

- A federal agreement allowing for capped Australian Government funding to support prisoners to access general supply medications (similar to the National Partnership on Essential Vaccines in which the Australian Government is responsible for the supply of vaccines, and the states may nominate to fund additional vaccines).
- A complementary scheme for subsidised medicines (similar to the Repatriation Pharmaceutical Benefits Scheme which provides veterans with PBS and other items that meet the specific clinical needs of veterans).
- Another \$100 special arrangement that the minister may establish for specifically targeted individuals (like the Take Home Naloxone Program in which the Australian Government subsidises the cost of naloxone).

In the short term, as the broader funding model is developed, the administrative and operational barriers identified to accessing the PBS in places of detention should be addressed (some of which overlap with the MBS considerations above) including:

- Enabling streamlined obtaining of Medicare cards, proving identities and removing the 'no card, no start' policy
- Supporting places of detention through establishing relationships with PBS pharmacies, that use Service Australia's online PBS claiming systems, including printing and electronic transmission of scripts, to reduce the delays in administering medications due to processing of scripts and transport of medications to the facility
- Exploring avenues for overseas doctors to be able to prescribe under the PBS where appropriate
- Revising pharmacy location rules to allow the establishment of PBS approved pharmacies in places of detention.

⁶¹ Parliamentary Library, The Pharmaceutical Benefits Scheme: a quick guide, Parliament of Australia, 2022.

Evaluate current national and state funding arrangements for custodial health and identify gaps and opportunities.

Healthcare funding in places of detention needs to be transparent and reported on to provide an overview of how funding is being spent across jurisdictions and identify gaps in service provision. Jurisdictions need to take a consistent approach to how healthcare funding is tracked and measured as this would support comparison of jurisdictions on equivalent terms. This information would form the foundation for transparent and needs-based funding models.

Expenses related to delivery of health services is generally not tracked or appropriately measured to enable informed comparison or decisions to be made regarding the adequacy of funding. For example, the Productivity Commission's Report on Government Services attempts to break down the health expenditure for corrective services across jurisdictions – however health expenditure cannot accurately be captured where prisoner health costs may be incurred by health departments or other agencies, or where prisoner health expenditure cannot be disaggregated from other prisoner operating expenditure. Addressing these limitations and ensuring consistency in measurement will support a fulsome system view of funding across jurisdictions and inform joint Australian Government, state and territory funding models.

Implications for the National Partnership Agreement.

The National Partnership Agreement should articulate the contributions of the Australian Government and states and territories to deliver needs-based health care, support access to universal health care and is inclusive of First Nations concepts of health and wellbeing.

The model should address the specific complex care needs of First Nations people in places of detention, supporting the provision of high quality and culturally appropriate assessments, treatment, follow-ups, throughcare and medication.

The standard of care that the funding model provides for should go above and beyond the care available in the community. Equivalence of care to the community assumes that care in the community is appropriate or sufficient – in reality, there are similar barriers for First Nations people to access and receive high-quality health care in the community. Additionally, First Nations people in places of detention are more likely to have greater, more complex needs and require support above what is available in the community. A future funding arrangement should work to achieve the best possible health outcomes for First Nations people in places of detention, rather than meeting a standard that may not achieve the desired level of care and does not contribute to Closing the Gap.

The model should utilise Medicare, the Medicare Benefits Schedule, and the Pharmaceutical Benefits Scheme as mechanisms to incorporate Australian Government funding, though they are not the only mechanisms that could or should be employed to support funding in places of detention. The funding pilot should explore different funding models for holistic, high-quality health services.

3.4.7 Establish reporting and data collection processes for outcomes, services and funding

The national program of work should include the creation of a national minimum data set and ensure commitment from states and territories to capture and report on the agreed datapoints. The dataset would inform national coordinated decision-making and promote transparency and accountability in line with the principles under Recommendation 1. This must be done in partnership with the Aboriginal community-controlled health sector to develop appropriate measures. These measures should include:

- Performance targets for the national health outcomes
- Adherence to the national standards
- Health expenditure
- Workforce
- Infrastructure.

3.4.8 Develop a national prison health workforce strategy to support the delivery of culturally safe health care in places of detention

The people who work in our places of detention set the culture and determine how effective health services can be. Ideally, the workforce is made up of staff who reflect the population within these places of detention and is trauma-informed with a deep appreciation for history and respect for those who are being detained. They would see those who are in these places as people with rights to health care, dignity and respect in the way all aspects of their sentence are carried out. This should also apply for those on remand, perhaps even more so. This is reportedly not the case.

The national program of work should include collaboration with NACCHO to develop a workforce strategy that aims to achieve these desired outcomes, ultimately leading to more effective delivery of health services to people in places of detention. The strategy should address the following key challenges:

- Recruitment of First Nations people into custodial health services and recruitment practices that ensure staff will promote a culture of respect and dignity in the treatment of those in places of detention – including increasing role attractiveness, creating a workforce pipeline and improving career opportunities.
- Tailored education, training and support for all health and custodial staff to support culturally safe health care.

A workforce strategy that supports increased numbers of First Nations people across all roles will improve the system.

Stakeholders highlighted the importance of having First Nations workers deliver health services to First Nations people in places of detention – particularly in their ability to create culturally safe environments and establish trust. The workforce strategy should be developed in partnership with the community-controlled health sector to build a pipeline of First Nations healthcare workers into

the future, for example through traineeships and other work experience pathways. The workforce strategy should also focus on the recruitment of First Nations people into roles in the broader custodial system, including leadership, administration and security. Additionally, the strategy should consider opportunities to support individuals with lived experience to form part of the care workforce through roles such as support officers, transition to community roles, visitor schemes and advocacy.

The strategy should specifically target the expansion of the Aboriginal Health Practitioner workforce.

Aboriginal Health Practitioners (AHPs) are essential to the health workforce due to their unique ability to provide culturally competent care, improve access to healthcare services, promote health and prevent disease, and address health inequities. Within places of detention, they play an important role in enhancing the quality of care for their First Nations patients.

There is currently not a sufficient pipeline of trained AHPs to meet the need of the custodial health system. Significant investment is required to build up this workforce and any strategy endorsed through the National Partnership Agreement should be accompanied by adequate resourcing.

All health and custodial staff need to have high levels of cultural safety, an understanding of trauma and the importance of facilitating access to high-quality health care.

The workforce strategy needs to mandate ongoing training and support for custodial and health staff to build their understanding and capabilities in delivering trauma-informed and culturally safe health care. This would support people in places of detention accessing health care, mitigating the risk of adverse health events, and promoting an overall more supportive facility environment with reduced behavioural incidents.

State and territory governments should partner with ACCHOs to co-design a culturally responsive education and training curriculum tailored specifically to the needs of staff working in custodial health. This training will provide education to non-Indigenous staff on how to implement culturally safe and trauma-informed ways of working, and better support their First Nations colleagues and clients.

Correctional officers are the gateway to detainees accessing healthcare services and, in this role, should be trained in care escalation pathways, de-escalation methods, be health literate including an appreciation of complex health and disability needs (particularly cognitive disabilities and neurodevelopmental conditions) and how they can present, as well as understanding how trauma can impact behaviour. Health staff should also undergo additional training in applying a holistic approach to care delivery, to include social and emotional wellbeing in their everyday practice to better respond to the health needs of First Nations people in places of detention.

3.4.9 Develop an infrastructure strategy to support the delivery of culturally safe health care in places of detention

This review heard that infrastructure is often not appropriate to deliver high quality and culturally safe healthcare services to First Nations people in places of detention. Current facility structures were often considered inadequate due to overcrowding and/or dated infrastructure that have not

been replaced.⁶² Additionally, health service delivery structures were reported as often not fit-for-purpose, where in one case the ACCHO that was delivering care into a place of detention was using an old cell instead of a health clinic. The types of facilities and how easily they can be accessed is important to providing therapeutic services and fostering a safe environment to deliver care.

There needs to be a more coordinated approach to ensuring health facilities are fit-for-purpose. This should involve standards for the design and construction of new health facilities, designed by people with health infrastructure expertise and First Nations communities to ensure they are clinically appropriate and accommodate practices and beliefs related to health and healing whenever possible within the custodial environment.

3.5 Recommendation 5: Facilitate the leadership of the Aboriginal community-controlled health sector in the policy, design and delivery of health services in partnership

Current state: Community-controlled health services are not supported to be involved in all levels of decision-making relating to First Nations health care in places of detention.

Opportunity: Embedding and supporting the community-controlled health sector to be able to lead in the policy design and development of culturally safe, well connected health services in places of detention in partnership with Governments.

Genuine partnership with the Aboriginal community-controlled health sector in the governance, design and delivery of health services is essential for achieving improved long-term outcomes for the physical health and social and emotional wellbeing of First Nations people in places of detention. In line with CtG Priority Reforms 2 and 3, as well as findings from the Productivity Commission Report, this involvement of the sector should be embedded at national, state and local levels to ensure a genuine First Nations-led approach. Recommended approaches to partnership with the community-controlled health sector at the national, state and local levels are outlined overleaf.

Support the capacity and capability of ACCHOs to lead decision-making processes.

Relevant governments should ensure that representatives from the community-controlled health sector are able to engage effectively and are supported to lead decision-making processes and conversations. This includes appropriate funding to ensure ACCHOs can be resourced to support ongoing involvement in governance and service design, and the provision of training programs and resources to supplement the leadership and organisational capabilities of the community controlled sector, where the sector feels that it is required.

ACCHOs need to be appropriately funded (through grants or other block funding) and resourced to support their involvement in governance and service design alongside ongoing service delivery in the community. Funding for this should cover:

⁶² PwC and Department of Health, Clinical Excellence Division, Offender Health Services Review, Queensland Government, 2018; Office of the Inspector of Custodial Services, Prisoner access to secure mental health treatment, WA Government, 2018.

- Resources to boost capabilities and ensure representatives are supported to lead and contribute to discussion and decision-making.
- Staffing costs to support ongoing delivery of programs while representatives are required to attend meetings and workshops.
- The time taken to attend committee meetings and co-design workshops for service development.

Recommended approaches to co-leadership and decision-making:

- **National:** Partnership at the national level sets a precedent and expectation for First Nations governance at state and local levels. Collaboration with the community-controlled health sector should be embedded in the National Partnership Agreement described above (Recommendation 4), whereby NACCHO and affiliates are embedded in national governance and decision-making to drive improved outcomes across Australia.
- **State and territory:** States and territories should be mandated to establish formal mechanisms to partner with NACCHO affiliates through state-wide governance committees. NACCHO affiliates can provide leadership to ensure the appropriate systems and supports are in place across custodial health settings, services and workforces to deliver culturally safe care. This partnership should be informed by the national partnership model described above.

In this arrangement, governance committees should include state and territory health and justice department representatives, senior First Nations health representatives and representation from NACCHO affiliate organisations to agree priorities, target outcomes and accountabilities in line with the national vision and strategy (outlined above). This will ensure that the development of culturally safe and trauma-informed models of care and health workforce strategies are driven by the community-controlled health sector.

- **Local:** ACCHOs should be invited to co-lead local governance, service design and delivery to enable a model of health care that reflects the cultural nuance of local communities.

Central to this involvement is the principle of choice. ACCHOs should be invited, but never forced, to provide input either delivering in-reach health services within facilities or acting in an advisory capacity to co-design a tailored, model of care to support First Nations people in places of detention local to them.

This arrangement may be challenging in the ACT and Tasmania where there is only one ACCHO that delivers community services. In the instance where the local ACCHO does not wish to provide in-reach services to facilities, states and territories should increase investment into building the capacity and capability of the custodial health workforce, including targeted recruitment of First Nations health workers.

3.6 Recommendation 6: Health and justice ministers pilot alternative, therapeutic models of custody for First Nations people, prioritising mothers and young people

Current state: Places of detention can be trauma-inducing environments and current punitive models do not support culturally safe care.

Opportunity: Explore and pilot therapeutic models of custody prioritising First Nations mothers and young people that respond to, rather than oppose, principles of social and emotional wellbeing.

Alternative therapeutic models of custody are driven by values of rehabilitation, community and skills development to improve health and social outcomes, and ultimately reduce risk of recidivism following release from places of detention. These models present a significant opportunity to positively improve long-term health outcomes of First Nations people in places of detention by reducing their repeated exposure to justice systems leading to traumatic removal from family and community. This would be of particular benefit to individuals that may have experienced multiple short sentences and long periods of time on remand.

Culturally safe models of care are essential; however, they cannot provide their maximum value when being retrofitted to a correctional system that is designed to punish and isolate rather than rehabilitate. Connection to family, community, Country and culture are core components of social and emotional wellbeing (Figure 3). All these components are stripped from people as they enter mainstream places of detention, contributing to the high rates of mental illness and trauma and inhibiting successful rehabilitation and reintegration back to the community.

Figure 3 | Model of social and emotional wellbeing⁶³



There is opportunity to draw on successful Australian and international examples to pilot therapeutic models of custody prioritising First Nations mothers and young people.

There is an opportunity to prioritise First Nations women and young people in places of detention for pilots of alternative models of custody on a smaller scale. This review found examples of successful programs in Australia and internationally that could be further investigated for potential adaptation to local settings.

The following principles could be used to underpin any pilot programs for therapeutic models of custody:

- Governed and designed by First Nations people and organisations.
- Supported by state and local investment.
- Evidence-based, with a view to international examples of success (e.g. Diagrama model of youth justice in Spain,⁶⁴ Indigenous Community Corrections Initiative in Canada,⁶⁵ prison-based therapeutic democratic communities in the United Kingdom⁶⁶).

⁶³ Adapted from Gee, Dudgeon, Schultz, Hart and Kelly, 2013

⁶⁴ Diagrama Foundation. A Blueprint for Change: Adapting the lessons of the Spanish Youth Justice System to the Northern Territory. October 2019.

⁶⁵ Public Safety Canada. Evaluation of the Indigenous Community Corrections Initiative. March 2021

⁶⁶ Bennet and Shuker. The potential of prison-based therapeutic democratic communities. International Journal of Prison Health. 2017. 13 (1): 19-24, doi: 10.1108/IJPH-08-2016-0036.

- Tailored to the needs of specific populations and local needs (e.g. First Nations women in Alice Springs).
- Driven by clear outcomes and objectives.
- Monitored and evaluated through specific performance indicators with an eye to replicability or expansion.

The case studies below highlight some examples of alternative models of custody that have shown success in improving the health and social outcomes for First Nations people in custody. These case studies include elements that may be adapted and applied to suit specific populations of First Nations women and young people across Australia.

CASE STUDY A: Mparntwe/Alice Springs Alternative to Custody (ATC) Program⁶⁷

The Mparntwe/Alice Springs ATC Program (the Program) is a community-based approach to reducing incarceration and recidivism for First Nations women. The aim of the Program is to deliver tailored, community-based rehabilitation programs for First Nations women at risk of offending, or reoffending who have been diverted, defected, mandated or self-referred. The Program is currently operated by Drug and Alcohol Services Australia (DASA), on a residential facility known as the 'Life Skills Camp' (the Camp). The Camp can house up to 10 women and their children, however the Program has capacity for up to 37 women.

Involvement in the ATC Program enables women to engage with therapeutic, community-based services including in-reach psycho-therapeutic services delivered by Central Australian Aboriginal Congress.

The Program was initially piloted for 18 months in 2019 where referrals almost doubled the Camp's capacity (67 women were referred to the Program in 2019). An independent evaluation of the pilot revealed that, for the 20 women who completed the Program, the ATC approach contributed to improved health and wellbeing outcomes for women serving sentences. Target outcomes for the Program that were found as being 'met' or "indications of being met' include:

- Client experiences improved physical and mental health.
- Clients with AOD issues abstain from usage during the Program.
- Clients with AOD issues abstain from usage for six months and post Program exit.
- Clients develop greater awareness of self and personal triggers that contribute to offending.

The Program has continued to operate following the pilot.

More information can be found here: [Alice Springs Alternative to Custody Program](#).

⁶⁷ Pandanus Evaluation. Alice Springs Alternative to Custody Program Evaluation Report, November 2022

CASE STUDY B: Diagrama model of youth “re-education” in Spain⁶⁸

The Diagrama Foundation (Diagrama) has successfully implemented over 35 “re-education” (detention) centres for young people in the criminal justice system across different regions of Spain. This model relies on a therapeutic, community-centred approach to support young people with a wide range of complex health and social needs, including learning difficulties and intellectual disability, mental illness and substance use challenges.

The Diagrama model of care focuses on therapeutic elements of:

- Relationships and emotions
- Cognition (interventions and thinking skills)
- Behaviour and progression
- Healthy living
- Engagement with family, carers or other significant people
- Normal and engaging environments
- Access to education and activities

Facilities run under the Diagrama model have a much larger proportion of social educators who provide direct support to young people through their daily activities including education, vocational training and leisure activities. Alternatively, security staff in these facilities are much less numerous, have little to no involvement in the day-to-day care of young people and are used only as a last resort in incident management.

A 2019 review of the Diagrama model revealed a recidivism rate of 13 per cent for young people following program completion. In 2022-2023, approximately 62 per cent of people under youth justice supervision in Australia had been supervised in a previous year, with First Nations young people more likely to have been previously under supervision than non-Indigenous young people.⁶⁹

More information on the implications of adapting the Diagrama model to the NT can be found here: [A Blueprint for Change: Adapting the lessons of the Spanish Youth Justice System to the NT](#)

⁶⁸ Diagrama Foundation. A Blueprint for Change: Adapting the lessons of the Spanish Youth Justice System to the Northern Territory. October 2019.

⁶⁹ Australian Institute of Health and Welfare. Youth justice in Australia 2022-2023.

4 Implementation considerations and timeframes

This section outlines the key considerations and proposed timeframes for the implementation of the recommendations presented in this review.

4.1 Overarching considerations

The recommendations presented in this review focus on system-level reform and include a comprehensive set of proposed actions for the Australian, state and territory governments. Overarching considerations for the implementation of the six recommendations are outlined below, accompanied by a suggested phased approach for specific actions summarised in Table 6.

- **Successful, system-level reform requires commitment from all governments to sustained action over time.** This includes in the long-term planning, funding and collaboration to deliver on actions that will drive significant improvement in health outcomes for First Nations people in places of detention.
- **Significant investment is required to drive and sustain change.** Current investment, while it needs to be maintained, is insufficient to deliver on the recommendations and program of work outlined in this report. Appropriate funding is a primary consideration for Australian, state and territory governments and needs to accompany the implementation of any reform actions.
- **The proposed program of work must draw on the strength and wisdom of First Nations leadership.** The recommendations and program of work outlined in this report cannot be delivered without the leadership of First Nations people. Actions have been proposed at the national, jurisdictional and local levels – all of which should involve genuine partnership with First Nations leadership and organisations to fully benefit from communities' lived experience and expertise in creating change that has real and positive impact for First Nations people.
- **Urgent action must be taken to ensure transformative change.** While this review proposes a phased approach to the implementation for actions in the short, medium and long term, this approach is designed only in the recognition that some actions take longer to establish – for example the design and implementation of inaugural national standards of care. Given the findings outlined in this report, this review recommends an urgent and proactive approach to implementing change and recognises that an incremental mindset is not sufficient to achieve the proposed reform agenda.
- **Existing systems and mechanisms can be successfully leveraged.** Most actions contained in this report leverage existing mechanisms that promote quality and safety in the health system to be applied to places of detention to ensure they are of high quality. Where possible, it is not recommended that parallel or duplicative structures are implemented but rather there is an overarching approach to bring custodial health in line with the mainstream healthcare system.

A phased approach could be considered for the implementation of the actions required to fulfil the recommendations, considering the timeframes required to enact system level reform. These are summarised in Table 6 below.

Table 6 | Proposed implementation timeline for recommendation actions

Short-term	Medium-term	Long-term
<p>Shared activities:</p> <ul style="list-style-type: none"> • Health and justice ministers agree to national reform principles to drive reform • Establish a National Partnership Agreement to govern the reform of First Nations health services in custodial settings • Develop and agree on a national program of work 	<p>Shared activities:</p> <ul style="list-style-type: none"> • Develop national health and wellbeing outcomes and targets • Develop models of care • Develop national standards of care • Evaluate existing funding and pilot funding models • Confirm measures and data that will be sought for outcomes and targets • Develop strategies to grow First Nations workforce • Develop infrastructure standards 	<p>Shared activities:</p> <ul style="list-style-type: none"> • Implementation of strategies and actions • Prepare report on progress, track targets against Closing the Gap • Evaluate effectiveness of programs and revise approach as needed • Explore opportunities for transformative models of care and alternative models of custody
<p>State and territories:</p> <ul style="list-style-type: none"> • Immediately address current practices that violate prisoners' rights • Establish formal partnerships with ACCHOs at state and local level 	<p>State and territories:</p> <ul style="list-style-type: none"> • Agree to national program of work • Sign up to national health standards for custodial settings • Agree to provision of information and data on services and funding • Explore service delivery opportunities with ACCHOs 	<p>State and territories:</p> <ul style="list-style-type: none"> • Transfer justice health responsibilities to health departments • Connect custodial and public health systems to support continuity of care

Appendix A Glossary

This section explains the key terms used in this document (Table 7).

Table 7 Glossary of key terms

Term	Definition
715 health check	This is a Medicare subsidised primary health assessment available to Aboriginal and Torres Strait Islander people
Aboriginal Health Practitioner	Aboriginal and Torres Strait Islander Health Practitioners are registered healthcare practitioners who provide clinical services and patient care with a focus on culturally safe practice for Aboriginal and Torres Strait Islander people.
Aboriginal Health Worker	Health workers that are members of the First Nations communities where they work that have been trained to support holistic primary healthcare provision for their communities
ACSQHC	Australian Commission on Safety and Quality in Health Care
BBV	Blood-borne virus
Closing the Gap (CtG)	The goal of eliminating or significantly reducing the health and socio-economic disparities experienced by First Nations people compared to non-Indigenous people in Australia.
DASA	Drug and Alcohol Services Australia
First Nations People	People of Aboriginal or Torres Strait Islander descent who identify as an Aboriginal or Torres Strait Islander.
Health	As defined in NACCHO's Constitution – "Aboriginal health' means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life'
HSD	Highly Specialised Drugs are a set of pharmaceuticals which are subsidised through the Pharmaceutical Benefits Scheme (PBS) and administered under s100 of the National Health Act 1953.
IHPA	Independent Hospital Pricing Authority

Term	Definition
NSQHS	National Safety and Quality Health Service
Person on remand	An individual who is held in custody while awaiting for trial or sentencing. A person on remand may be held in prison, police cells, court cells or psychiatric facilities as required. ⁷⁰
Place of Detention	Place of detention refers to any form of detention, imprisonment, or institutionalisation of a person in a public or private institution which that person is not permitted to leave at will, by order or under de facto control of a judicial, administrative, or any other authority.
RACGP	Royal Australian College of General Practitioners

⁷⁰ Department of Correctional Services. What is remand. Government of South Australia. [Accessed 07.05.2024]

Appendix B Review methodology

The review was conducted from late December 2023 to June 2024 and consisted of three stages:

1. A literature review of recent research and evidence on healthcare in places of detention for First Nations people, guided by key lines of enquiry (KLEs). The literature was summarised and used to inform the review's approach to the stakeholder consultation, including the roundtables.
2. Stakeholder engagement through targeted consultations and roundtable meetings. Nous engaged with stakeholders across state and territory health and corrections departments, peak bodies and advocacy groups, lived-experience organisations, Aboriginal community-controlled sector representatives and academic experts.
3. Refinement of recommendations including testing with the project Advisory Group and development of a Final Report.

The review has delivered three key deliverables:

1. **Literature Summary:** a review of published and grey literature on First Nations health care in prisons and related concepts such as equivalence of care and culturally appropriate care.
2. **Consultation Summary:** capturing the views of stakeholders on the KLEs across state and territory health and corrections departments, peak bodies and advocacy groups, lived-experience organisations, Aboriginal community-controlled sector representatives and academic experts.
3. **Final Report** (this document – draft): presenting recommendations for reform that have been developed in consultation with key stakeholders and tested with the Advisory Group and Department of Health and Aged Care.

The review methodology has been designed to ensure that evidence includes the voices of First Nations people.

Priority has been given to voices of First Nations people, including those with lived experience of places of detention and this is also reflected in the recommendations. This report aims to respect the history and depth of First Nations people's knowledge and understanding in this area and recognises the strength of First Nations people in the leadership and design of the most effective solution for their communities.

Inputs to the review.

This report examines evidence from several sources, as outlined in below. Evidence provided to the review has not been attributed to any individual or organisation. Inputs include:

- 29 stakeholder consultations
- Over 120 documents reviewed
- 4 roundtable meetings (ACT, NT, WA, VIC)
- 3 advisory group meetings

Appendix C Stakeholders consulted in this review

Stakeholders were consulted through interviews (Table 8) and roundtables (Table 9, Table 10, Table 11 and Table 12). Stakeholders included peak bodies, experts, advocacy groups, lived experience organisations, service delivery organisations, throughcare providers and state and territory government representatives.

Table 8 | Stakeholders consulted in interviews

Category	Organisation
Peaks, experts and advocacy groups	<ul style="list-style-type: none"> • Aboriginal Legal Rights Movement SA • Curtin University / Justice Health Group • Mr Damien Linnane • Lowitja Institute • Partnership for Justice in Health • Justice Policy Partnership • NACCHO Affiliates
Lived experience organisations	<ul style="list-style-type: none"> • Sisters Inside
Service delivery organisations	<ul style="list-style-type: none"> • Winnunga Nimmityjah Aboriginal Health and Community Services, ACT • Danila Dilba Health Service, NT • Gayaa Dhuwi (Proud Spirit) • Healing Foundation • Waminda • Marumali Program • Central Australian Aboriginal Congress • Dhelkaya Health
Throughcare providers	<ul style="list-style-type: none"> • Outcare • Gurehlgam • Shine for Kids • North and West Remote Health, Community and Outreach Healthcare • Five Bridges

Category	Organisation
State and territory government representatives	<ul style="list-style-type: none"> • ACT: <ul style="list-style-type: none"> • ACT Corrective Services • Canberra Health Services • Department of Health • NSW: <ul style="list-style-type: none"> • Justice Health & Forensic Mental Health Network • NT: • NT Health • Queensland: <ul style="list-style-type: none"> • Queensland Health • Office for Prisoner Health and Wellbeing • Queensland Corrective Services • SA: <ul style="list-style-type: none"> • SA Prison Health Service • Central Adelaide Local Health Network • SA Health • Department for Correctional Services • Tasmania: <ul style="list-style-type: none"> • Tasmania Health Services • Department of Justice • Victoria: <ul style="list-style-type: none"> • Justice Health • Corrections Victoria • Department of Health • WA: <ul style="list-style-type: none"> • Corrective Services, Department of Justice • Department of Health

Table 9 | Stakeholders consulted in NT roundtable

Category	Organisation
Peaks, experts and advocacy groups	<ul style="list-style-type: none"> • North Australian Aboriginal Justice Agency (NAAJA)
Service delivery organisations	<ul style="list-style-type: none"> • Danila Dilba Health Service

Category	Organisation
State and territory governments	<ul style="list-style-type: none"> • NT Department of the Attorney General and Justice • National Aboriginal and Torres Strait Islander Health Collaboration • Chief Aboriginal Health Officer, NT • NT Health • NT Health Central Australia

Table 10 | Stakeholders consulted in WA roundtable

Category	Organisation
Peaks, experts and advocacy groups	<ul style="list-style-type: none"> • Aboriginal Health Council of WA • Council of Aboriginal Services WA • University of Western Australia
Lived experience organisations	<ul style="list-style-type: none"> • Ngalla Maya: Noongar Employment Access
Service delivery organisations	<ul style="list-style-type: none"> • Derbarl Yerrigan Aboriginal Medical Health Service
State and territory governments	<ul style="list-style-type: none"> • National Aboriginal and Torres Strait Islander Health Collaboration • Office of the Inspector of Custodial Services, WA • South Australian Prison Health Service • WA Department of Health • WA Department of Justice

Table 11 | Stakeholders consulted in ACT roundtable

Category	Organisation
Peaks, experts and advocacy groups	<ul style="list-style-type: none"> • National Aboriginal Community Controlled Health Organisation (NACCHO) • Alcohol Tobacco and Other Drug Association ACT • Australian Medical Association • Australian Indigenous Doctors' Association • Healing Foundation • National Justice Project • Australian Centre of Research Excellence in Offender Health, National Health and Medical Research Council (NHMRC)

Category	Organisation
Australian government	<ul style="list-style-type: none"> • Australian Institute of Health and Welfare • Department of Health and Aged Care
State and territory governments	<ul style="list-style-type: none"> • ACT Corrective Services • Canberra Health Services • Justice Health & Forensic Mental Health Network NSW • National Aboriginal and Torres Strait Islander Health Collaboration

Table 12 | Stakeholders consulted in Victoria roundtable

Category	Organisation
Peaks, experts and advocacy groups	<ul style="list-style-type: none"> • Lowitja Institute • Victorian Aboriginal Community Controlled Health Organisation (VACCHO) • Victorian Aboriginal Health Service (VAHS) • Wathaurong Aboriginal Co-operative • First People's Disability Network • Institute for Urban Indigenous Health (IUIH)
Service delivery organisations	<ul style="list-style-type: none"> • Dhelkaya Health • Western Health
State and territory governments	<ul style="list-style-type: none"> • Victorian Department of Health • Victorian Department of Justice and Community Safety

Appendix D Links to the Royal Commission into Aboriginal Deaths in Custody (RCIADC)

Table 13 | Alignment of recommendations to findings and recommendations in the RCIADC

Recommendation	Corresponding link to RCIADC
1. Health and justice ministers agree to national reform principles to drive action	<ul style="list-style-type: none"> • Rec 328. That as Commonwealth, State and Territory Governments have adopted Standard Guidelines for Corrections in Australia which express commitment to principles for the maintenance of humane prison conditions embodying respect for the human rights of prisoners, sufficient resources should be made available to translate those principles into practice. • Rec 153c. Whatever administrative model for the delivery of prison medical services is adopted, it is essential that medical staff should be responsible to professional medical officers rather than to prison administrators. (3:280)
2. Health and justice ministers take steps to immediately cease current practices that violate prisoners' rights.	<ul style="list-style-type: none"> • Rec 333. While noting that in no case did the Commission find a breach of the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment, it is recommended that the Commonwealth Government should make a declaration under Article 22 of the Convention and take all steps necessary to become a party to the Optional Protocol to the International Convention on Civil and Political Rights in order to provide a right of individual petition to the Committee Against Torture and the Human Rights Committee, respectively
3. Establish a National Agreement and Partnership to Govern First Nations Health Services in places of detention to lead reform	<ul style="list-style-type: none"> • Rec 1. That the Commonwealth Government and State and Territory Governments, in consultation with ATSIC, agree upon a process which ensures that the adoption or otherwise of recommendations and the implementation of the adopted recommendations will be reported upon on a regular basis with respect to progress on a Commonwealth, State and Territory basis;
4. Implement a national program of work for First Nations health care in	<p>Health outcomes:</p> <ul style="list-style-type: none"> • Rec. 48. That when social indicators are to be used to monitor and/or evaluate policies and programs concerning Aboriginal people, the informed views of Aboriginal people should be

Recommendation	Corresponding link to RCIADIC
places of detention, led by the National Partnership	<p>incorporated into the development, interpretation and use of the indicators, to ensure that they adequately reflect Aboriginal perceptions and aspirations.</p> <p>Model of care:</p> <ul style="list-style-type: none"> • Rec. 152 Corrective Services in conjunction with Aboriginal Health Services and such other bodies as maybe appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions, having regard to: <ul style="list-style-type: none"> • standard of general and mental health care, • extent to which serves are culturally appropriate, • involvement of AHS in provision of healthcare, • exchange of relevant information between prison health and external health agencies • establishment of guidelines for exchange of information between prison medical staff, corrections staff and corrections administrators • Development of protocols for management of risk behaviour. <p>Continuity of care</p> <ul style="list-style-type: none"> • Rec 157 efforts must be made by the Prison Medical Service to obtain a comprehensive medical history for the prisoner including medical records from a previous occasion of imprisonment, and where necessary, prior treatment records from hospitals and health services. In order to facilitate this process, procedures should be established to ensure that a prisoner's medical history files accompany the prisoner on transfer to other institutions and upon re-admission and that negotiations are undertaken between prison medical, hospital and health services to establish guidelines for the transfer of such information. <p>Standards:</p> <ul style="list-style-type: none"> • 194. That Commonwealth, State and Territory Governments, in negotiation with appropriate Aboriginal communities and organisations, agree upon appropriate performance indicators for programs relevant to Aboriginal communities and organisations. <p>Workforce:</p> <ul style="list-style-type: none"> • Rec. 133 All staff of Prison Medical Services should receive training to ensure that they have an understanding and

Recommendation	Corresponding link to RCIADIC
	<p>appreciation of those issues which relate to Aboriginal health, including Aboriginal history, culture and lifestyle so as to assist them in their dealings with Aboriginal people. Prison Medical Services consult with Aboriginal Health Services as to the appropriate information and training required. Those agencies responsible for the delivery of health services in correctional institutions should endeavour to employ Aboriginal persons in those services.</p> <ul style="list-style-type: none"> Rec 174. That all Corrective Services authorities employ Aboriginal Welfare Officers to assist Aboriginal prisoners, not only with respect to any problems they might be experiencing inside the institution but also in respect of welfare matters extending outside the institution, and that such an officer be located at or frequently visit each institution with a significant Aboriginal population. <p>Infrastructure:</p> <ul style="list-style-type: none"> Rec 251. That access to health care services and facilities, including specialised diagnostic facilities, in areas of Aboriginal population should be brought up to community standards. The greater needs, for the time being, of Aboriginal people should be fully recognised by the responsible authorities in their consideration of the allocation of staff and equipment. Rec 253. That the physical design of and methods of operating health care facilities be attuned to the needs of the intended patients. Particularly where high concentrations of Aboriginal people are found, their special needs in these regards should be taken into consideration. The involvement of Aboriginal people in the processes of designing such facilities is highly desirable.
<p>5. Facilitate the leadership of the Aboriginal community controlled health sector in the policy, design and delivery of health services in partnership</p>	<ul style="list-style-type: none"> RCIADIC Rec. 2 there be established in each State and Territory an independent Aboriginal Justice Advisory Committee to provide each Government with advice on Aboriginal perceptions of criminal justice matters, and on the implementation of the recommendations of this report. Rec 192 That in the implementation of any policy or program which will particularly affect Aboriginal people the delivery of the program should, as a matter of preference, be made by such Aboriginal organisations as are appropriate to deliver services pursuant to the policy or program on a contractual

Recommendation	Corresponding link to RCIADIC
	<p>basis. Where no appropriate Aboriginal organisation is available to provide such service then any agency of government delivering the service should, in consultation with appropriate Aboriginal organisations and communities, ensure that the processes to be adopted by the agency in the delivery of services are appropriate to the needs of the Aboriginal people and communities receiving such services. Particular emphasis should be given to the employment of Aboriginal people by the agency in the delivery of such services and in the design and management of the process adopted by the agency.</p> <ul style="list-style-type: none"> • Rec 254. That health departments and other mainstream health authorities accept as policy, and implement in practice, the principle that Aboriginal people should be involved in meaningful ways in decision-making roles regarding the assessment of needs and the delivery of health services to the Aboriginal community. • Rec 258. That in areas where Aboriginal people are concentrated and the state or territory governments provide or intend to provide a particular service or services to Aboriginal people, the governments invite community-controlled Aboriginal Health Services to consider negotiating contracts for the provision of the services to Aboriginal people and also, where appropriate, to non-Aboriginal people.
<p>6. Health and justice Ministers responsible ministers pilot alternative, therapeutic models of custody for First Nations people, beginning with women and young people</p>	<ul style="list-style-type: none"> • Rec 184. That Corrective Services authorities ensure that all Aboriginal prisoners in all institutions have the opportunity to perform meaningful work and to undertake educational courses in self- development, skills acquisition, vocational education and training including education in Aboriginal history and culture. Where appropriate special consideration should be given to appropriate teaching methods and learning dispositions of Aboriginal prisoners.

Appendix E Nous' Organisational Architecture Framework

Nous' organisational architecture framework (NOAF) provides a structure that sets out key components of the current custodial health system. The NOAF was used as a tool to facilitate discussion and capture proposed opportunities and reforms across each of the key elements (see Figure 4).

Figure 4 | Nous' Organisational Architecture Framework

