



National review of First Nations health care in prisons: Stakeholder engagement summary

Australian Government Department of Health and Aged Care

7 June 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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Executive summary

The Australian Department of Health and Aged Care (the Department) has engaged Nous Group (Nous) and Ngarra Group to conduct an independent review of health care provided to First Nations people in adult prisons and youth detention facilities across Australia. Nous engaged with stakeholders across health, justice and the Aboriginal community-controlled sector through targeted consultations and roundtable meetings and this document presents a summary of the insights captured through these engagements.

The consultations aimed to answer the following questions, aligned to the overarching project lines of enquiry:

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

Engagements included:

- 11 state and territory consultations
- 7 peak, expert and advocacy group consultations
- 14 service delivery/Aboriginal Community Controlled Organisation (ACCO) consultations
- 4 Round table meetings in: Darwin (8 participants), Perth (11 participants), Canberra (14 participants), and Melbourne (16 participants)

Roundtable meetings were used to develop and agree a set of guiding principles to any reform recommendations that will be outlined in the Final Report. Suggested options for reform have been captured in this document, with the agreed guiding principles are outlined below.

- Cultural safety is integral to the delivery of appropriate healthcare services to First Nations people
- First Nations voices and leadership are essential
- Health is about the whole person
- Equitable health care is a human right
- Health services need to be integrated with the broader health system
- Addressing health care in prisons is essential to Closing the Gap
- Access to health care is a shared responsibility, and agencies need to be held accountable

1 Project background

1.1 Background and context

Concerns have been raised about the efficacy of health services for First Nations people in custody following several coronial inquiries into the deaths of First Nations people in custody.

State and territory governments are responsible through their own legislation for the delivery of corrective services, including the health care of prisoners incarcerated in state and territory prisons. However, there has been recent acknowledgement from Health Ministers and the Aboriginal and Torres Strait Islander Health Roundtable of the need for collaborative action to drive reform in prison health care.

The National Aboriginal and Torres Strait Islander Health Collaboration recommended an independent review of health care provided to First Nations people in adult prisons and youth detention facilities across Australia to understand the current state of healthcare delivery and identify opportunities and barriers for reform.

1.2 Project overview

The Australian Department of Health and Aged Care (the Department) has engaged Nous Group (Nous) to undertake this review (the Review). The Review presents findings and provides specific recommendations to the Australian Government on how the quality and access of healthcare services could be improved to make a difference to the outcomes experienced by First Nations people in custody. It examines:

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

1.3 Consultation summary and project deliverables

The consultation summary (this document) captures the views of 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. Stakeholder perspectives were sought through a combination of interviews and roundtable meetings.

This summary is delivered as part of a set of project deliverables, that also includes:

- Literature Summary (due 15 January 2024)

- Draft Report (due 8 May 2024)
- Final Report (due 7 June 2024)

Stakeholder engagement through targeted consultations and roundtable meetings will inform the development of recommendations for reform and a Final Report

2 Principles to guide reform options

A principles-based approach has been used to guide priority areas for reform

A set of guiding principles were developed from the Literature Summary and initial stakeholder consultations. Principles were presented at roundtable meetings and tested with participants. Based on their input, these were further developed and refined to guide the approach in building recommendations. The result of this process is presented in Table 1, which includes detail on the stakeholder discussion.

Table 1 Principles to guide reform

Principle	Description	Stakeholder discussion
Cultural safety is integral to the delivery of appropriate healthcare services to First Nations people	Health services need to be culturally safe and delivered in a trauma-informed way. Racial discrimination that influences who gets care, when and how needs to be eliminated.	<ul style="list-style-type: none"> • There was agreement across all round tables and consultations to the importance of health services being culturally safe and trauma-informed. This included being delivered by First Nations people, where possible. <ul style="list-style-type: none"> • Cultural safety also incorporates the cultural determinants of health and connections to family and community and should be defined by First Nations people. • Access to health care needs to be proactive and holistic and inclusive of cultural healing practices. • Pervasive racism affects who gets care, when and the how behaviour is assessed and managed, and how risk is perceived.
First Nations voices and leadership are essential	Health services should be designed, delivered and governed by First Nations people. Custodial systems and processes should also be informed by Aboriginal leadership.	<ul style="list-style-type: none"> • Models of care should be designed and informed by First Nation people <ul style="list-style-type: none"> • These can be informed by existing community-controlled health care and core services models. • Priority reform three of the Closing the Gap agreement, signed by all governments, commits to working in partnership with First Nations people. Custodial settings are government services and should be covered by this commitment.

Principle	Description	Stakeholder discussion
Health is about the whole person	The definition of “health” is underpinned by the holistic principle of social and emotional well-being. Access to person-centred health services in custody is a critical enabler for improved health and social outcomes and provides the pre-conditions for a better life.	<ul style="list-style-type: none"> • The term “health” when referring to First Nations people, needs to encompass social and emotional wellbeing. • It is essential to recognise the impact of social determinants of health and wellbeing on individuals, as well as the population of First Nations people in prisons. • People arrive in custodial systems with history, connections to family, responsibilities and (often) trauma. They can have complex disability, health and wellbeing needs which are untreated and undiagnosed. • Addressing health literacy, and ensuring access to good nutrition and the ability to translate these skills into life after custody • There needs to be a model of health and health care in prisons that is broader than the traditional medical model of care.
Equitable health care is a human right	Services should aspire to meet the complex needs of people in prison. People in custody are punished through the deprivation of liberty, not of health care (which is a human right under the Mandela Rules).	<ul style="list-style-type: none"> • Although “equivalence” is the international test for prison health standards and included in many legislative requirements, there was broad agreement that this concept is insufficient and will not meet the higher health needs of First Nations people in custodial settings. • The approach moving forward should be aspirational, and not limited to being equal to community services but rather greater than equivalence to external care. • Health services provided in prisons should address need – including health, mental health and disability related conditions. In particular, the high levels of trauma needs to be accounted for and addressed.
Health services need to be integrated with the	Custodial health needs to function as part of the broader, integrated health system to support	<ul style="list-style-type: none"> • Health care for people in custodial settings should not be disconnected from broader quality and regulatory requirements.

Principle	Description	Stakeholder discussion
broader health system	continuity of care with appropriate links to the custodial context.	<ul style="list-style-type: none"> • People and services within prisons need to be connected to services delivered in the community to enable continuity of care and successful reintegration back into the community post-release. • In order to be most effective, healthcare delivery should be overseen by the relevant health department, rather than justice or corrections • For individuals, families and communities, health care should be connected with information, treatment requirements and care needs communicated between health and custodial settings to support health outcomes – with consent.
Addressing health care in prisons is essential to Closing the Gap (CtG)	Prisons are government services and covered by the commitments and priority reforms of the CtG agreement.	<p>Closing the Gap (CTG) encompasses a set of priority reforms and targets across health, justice, economic and social policy. The significant numbers of First Nations people that are incarcerated is an issue for not just the justice targets but also for achieving many other health and education CTG targets.</p> <p>There is evidence that the imperatives expressed in the CTG priority reforms have had little impact on the delivery of health services in custodial settings.</p> <p>Solutions in this area need to be in line with the priority reforms for them to be effective for First Nations people.</p> <p>There is opportunity to improve health outcomes and make progress towards the CTG targets through the provision of planned and systematic health services in custodial settings based on good assessments.</p>
Access to health care is a shared responsibility, and agencies need to	Provision of health services in custodial settings is a shared responsibility of federal,	Health care is a system operating within a custodial system. The needs of the custodial system and safety and security will always

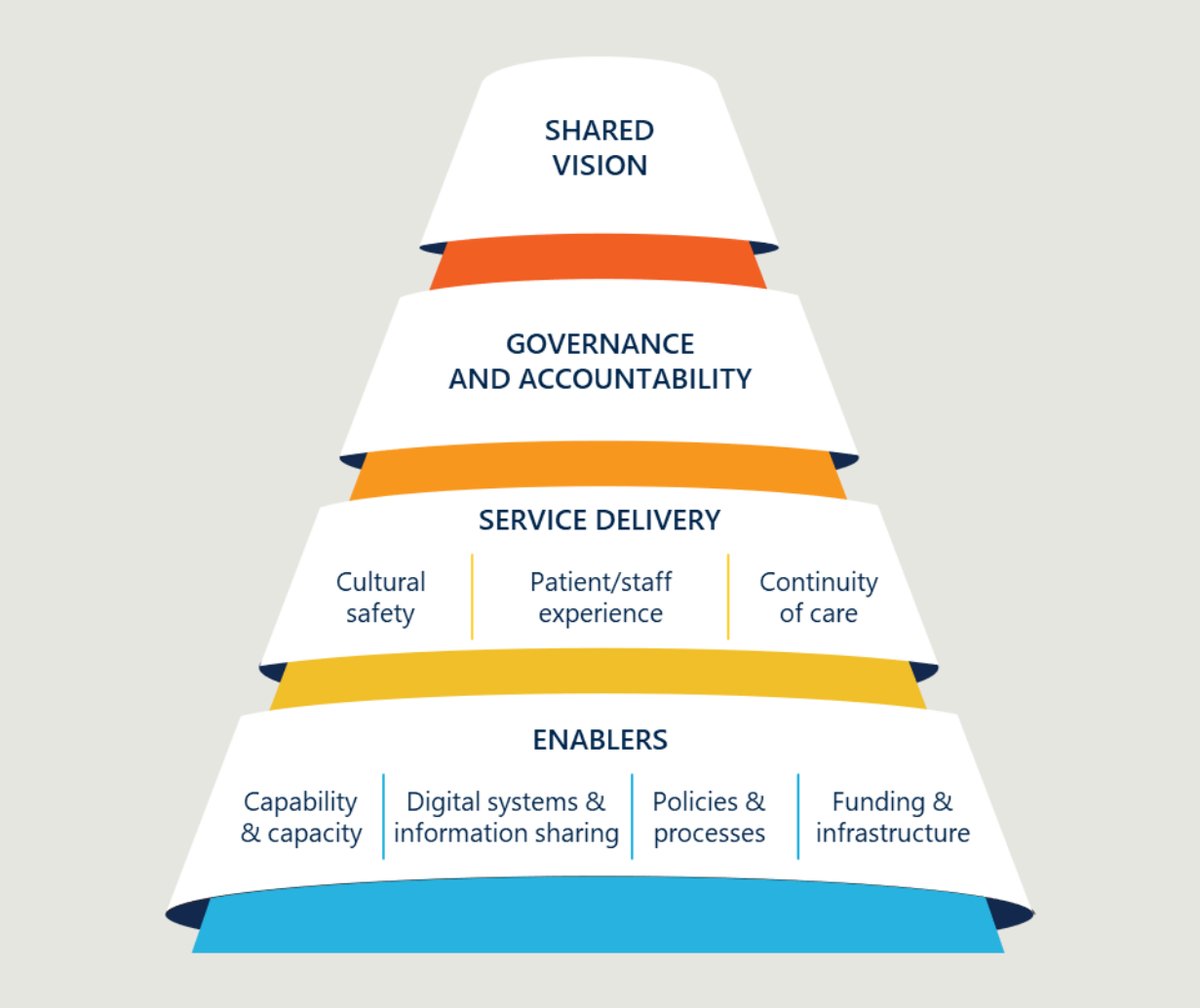
Principle	Description	Stakeholder discussion
be held accountable	state and territory governments. The Australian Government is responsible for the health for all Australians, while jurisdictions are responsible for the design, delivery, monitoring and reporting of health services in prisons.	<p>trump health and wellbeing needs of prisoners.</p> <p>Diffusive responsibility for health care across agencies can mean no-one is accountable for adverse outcomes. This issue is central to many coronial inquiries.</p> <p>In addition to the health and justice portfolios there are significant interactions with community services and disability which need to be understood and well-integrated into improving overall health outcomes.</p>

3 System approach to identifying opportunities for reform

Nous' organisational architecture framework (NOAF) has been used in consultations to describe and capture the key elements of the custodial health operating model. The NOAF is a tool that can be used to identify key elements that are essential to deliver high quality and safe health care to First Nations people in custody (Figure 1). It provides a helpful structure that sets out what exists, or should exist, in the current custodial health system, and facilitates a discussion of what each of these elements should look like to deliver improved healthcare services. The categories are:

- **Shared vision:** What is the shared vision and goal for First Nations custodial health care? (Section 4.2)
- **Governance and accountability:** Who should be responsible for the governance of custodial health? What accountability mechanisms will ensure high quality service? (Section 4.3)
- **Service delivery** (cultural safety, patient/staff experience, continuity of care): What is important for effective, culturally safe health service delivery? How do we ensure continuity of care to improve outcomes for people in prison? (Section 4.4)
- **Enablers** (capability and capacity, digital systems and information sharing, policies and processes, funding and infrastructure): What system enablers are necessary to achieve the shared vision? (Section 4.5)

Figure 1 NOAF



At each of the roundtable meetings, the NOAF was presented to the group with a proposed list of reform opportunities against each category of the framework. For the first roundtable (Perth) these opportunities were drawn from the Literature Summary and the initial stakeholder consultations. At the subsequent roundtables (Canberra, Darwin and Melbourne) these opportunities were built on and refined with inputs from the previous roundtables and consultations. A summary of these possible opportunities is presented in Table 2 below and discussed further in Section 4.

Table 2 Summary of suggested opportunities by NOAF element

NOAF element	Suggested opportunities
Shared vision	<ul style="list-style-type: none">• Develop national justice health strategy with clear objectives, monitoring and evaluation, and commitment from federal, state and territory governments to drive change• Develop national youth justice strategy that focuses on the specific requirements and needs of young people in custody• Establish national Justice Health Policy Partnership

NOAF element	Suggested opportunities
Governance and accountability	<ul style="list-style-type: none"> • Establish formal partnership agreements between health and justice at a policy and operational level to support interaction between the systems and articulate accountabilities for all relevant agencies • Embed First Nations leadership and input into national and local governance • Design national health care and data standards and measurement of effective, culturally safe healthcare delivery
Service delivery	<ul style="list-style-type: none"> • Establish integrated health services with robust throughcare to public and community-controlled health system to support continuity of care post-release • Develop culturally safe, holistic healthcare model that encapsulates physical, social, emotional and spiritual wellbeing and meets the needs of First Nations people • Explore evidence-based and culturally appropriate disability, mental health and AOD programs
Enablers	<ul style="list-style-type: none"> • Update information systems that support efficient information sharing, and data-driven service monitoring and reporting • Revise workforce practices (workforce planning, recruitment, training, etc.) to support a culturally safe environment and the ability to proactively identify health needs • Build fit-for-purpose infrastructure and standards for health facilities • Design appropriate and tailored funding arrangements and clear guidelines

4 Stakeholder perspectives

4.1 Overarching insights

Stakeholders are frustrated about the lack of progress – though are optimistic about the opportunities raised by Health Ministers.

There is already a significant understanding of the challenges and opportunities to delivering culturally safe healthcare services to First Nations people in custody.

As discussed in the Literature Summary, there is a wealth of knowledge and understanding that exists in the First Nations community and community-led services of the challenges faced by First Nations people accessing healthcare services in the custodial system. Through multiple Royal Commissions and Coronial Inquests and the Victorian Ombudsman's report, there is also a clear understanding of the consequences for First Nations people when this system fails.

Stakeholders that participated in these consultations expressed frustration with the lack of progress in improving health outcomes for First Nations people in custody, and referenced the numerous inquiries that have resulted in clear recommendations for change. There was a common sentiment and question around why they would provide their time and input into another process that just captures the same information that has been repeatedly shared in previous forums.

There is opportunity to explore more therapeutic models of incarceration to support improved health and wellbeing in custodial settings.

It was noted that many of the barriers experienced to delivering culturally safe health care could potentially be removed through the implementation of therapeutic models of incarceration or alternatives to custody. In the Northern Territory, the Mparntwe/Alice Springs Alternative to Custody (ATC) Program for women is an innovative, community-based approach to reducing First Nations incarceration and recidivism that has improved health and wellbeing outcomes for participants.

Progress towards improved health outcomes in prisons will not be made in isolation.

Stakeholders consistently expressed the view that to positively impact on the health and wellbeing of First Nations people and make progress towards the health targets outlined in the National Agreement on Closing the Gap, attention must also be focused on services delivered before and after a person enters the criminal justice system. Increased investment is needed to:

- **Keep people out of prison** i.e. through the increased age of criminal responsibility for juveniles; alternative options to incarceration and diversion programs; and improved services that address the social determinants of health including education and housing.
- **Stop people from returning to prison** i.e. through connection to community and public health services post-release; through adequate support for housing and employment

Stakeholders are hopeful that this project is an opportunity to effect change.

Stakeholders noted that this is the first consultation initiated by the Australian Government into this issue and were hopeful that it presents an opportunity to provide input into a strategy for change.

4.2 Shared vision

National leadership has been absent in this area; stakeholders welcome a common vision and are hopeful for change

Stakeholders told us...

- There is frustration at the notion of another review (this Review), despite a history of many reviews and Royal Commissions with recommendations yet to be addressed, such as:
 - Recommendations from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) and the Royal Commission into the Protection and Detention of Children in the Northern Territory. First Nations deaths in custody was raised several times as an ongoing issue, although this was noted to be outside the scope of this Review.
 - Recommendations from NACCHO's submission to RACGP in response to the Standards for Health Services in Australian Prisons.
- Priority reforms and targets from the National Agreement on Closing the Gap.
- A national approach should focus not only on the delivery of health services within prison walls, but the broader systemic factors that lead to the disproportionate imprisonment of First Nations people and their poor health outcomes. Priority reforms and targets from the National Agreement on Closing the Gap that address social determinants of health and criminogenic risk factors (e.g. those related to education, child protection) are essential in order to achieve long-term change.
- There is an opportunity for leaders to drive narrative and culture change. Across the justice and health systems this can change the way that prisoners are perceived and the negative impact systemic racism which drives additional barriers for First Nations people in custody and on remand.
- National leadership is essential in improving the integration and collaboration between primary health care delivered in prisons (funded and operated by jurisdictions) and in the community (funded and operated by primary health networks and the Australian Government).

Stakeholders suggested opportunities for reform...

Consider strengthening focus on improved national coordination and reform. These include concepts like;

- Some form of improved national coordination like a national justice health strategy or partnership that considers the unique environment for providing health services in prisons, and articulates:
 - Clear goal and objectives based on a First Nations model of health care

- Shared commitment from all levels of governments to improving health care to First Nations prisoners
- Alignment to the National Agreement on Closing the Gap and other priority recommendations and national strategies
- Implementation roadmap
- Monitoring and evaluation mechanisms.
- A set of national health service standards that all jurisdictions are required to adhere to.
- The establishment of a national Justice Health Policy Partnership (with similar Terms of Reference to the Justice Policy Partnership).
- A national youth justice strategy that focuses on the specific requirements and needs of young people in custody.

4.3 Governance and accountability

The governance and accountability for prison health care varies greatly across jurisdictions with no agreed national standards

Stakeholders told us...

- The governance and accountability mechanisms across jurisdictions are inconsistent and often unclear. Stakeholders called for strengthened accountability, including the identification and agreement of a specific agency/team that would be ultimately held accountable for the provision of health care to prisoners.
- The agencies responsible for the delivery of prisoner health services differ across the country, led sometimes by health and sometimes by justice. Some stakeholders expressed a preference for health departments to consistently oversee all healthcare delivery in prisons.
- In all cases stakeholders agreed services needed to be adequately resourced to meet the need. Services should also be in public hands not delivered with a profit motive by private providers.
- Decision-makers require better quality program data to understand the types of health services delivered in prisons and the performance of the services in achieving intended outcomes. Data for this is particularly poor when it comes to First Nations prisoners.
- First Nations people have varying levels of involvement in the governance of health care in prisons; often there is very little to no involvement in decision-making across the system. In some cases where ACCHOs deliver health services directly into prisons (e.g. Danila Dilba, Winnunga Nimmityjah), there is the opportunity for local First Nations governance, however this is uncommon and facility-specific.
- There is opportunity to establish national standards that define the baseline level of care that jurisdictions are required to deliver to prisoners. Currently, the type and standard of care is

highly variable across jurisdictions, with no national body to hold policy makers and service providers to account.

- Consistency is important to establish in terms of workforce (e.g. clinician to client ratios), types of services, and performance monitoring and reporting (e.g. KPIs).
- A lack of performance and monitoring standards (e.g. KPIs) means that insufficient data is collected to understand if services are meeting the needs of prisoners.

Stakeholders suggested opportunities for reform...

- Consider establishing clear accountability for the delivery of healthcare services in custodial settings, with a preference for prison health services to be governed by state/territory health departments.
- Consider designing national standards for the provision and monitoring of health care in prisons, including provisions relating to:
 - Health care quality and safety
 - Culturally safe and trauma-informed services/workforces/processes
 - Funding to specific services and program types
 - Information sharing between agencies.
- Consider conducting benchmarking exercise across jurisdictions to understand what “good” looks like.
- Consider developing mechanisms to embed First Nations leadership and governance into local and national decision-making.
- Consider establishing formal partnerships (e.g. MOU, community of practice) between justice/corrections and health at the operational level, including:
 - Terms of reference to clearly articulate responsibilities and accountability mechanisms for both health and justice departments.

4.4 Service delivery

There is significant opportunity to improve cultural safety in health care across all jurisdictions

Stakeholders told us...

- The prison environment is directly opposed to the core values of First Nations cultures (i.e. connection to family, community and Country) all of which impact on social and emotional wellbeing. Stakeholders described prisons as “trauma-inducing” and criminogenic, with many prisoners experiencing interpersonal and systemic racism, a loss of dignity and trust for the system and the services it provides.
 - Systemic racism presents barriers to effective care in the way:

- First Nations health is considered and prioritised at a policy and strategy level
- Custodial staff interpret and respond to health requests from First Nations people in custody
- Health staff diagnose and treat health needs of First Nations people in custody.
- Adoption of a holistic model of care is still in its infancy across many states and territories. South Australia has developed a specific model of care for First Nations prisoners, and other jurisdictions have models under development with input from First Nations people. Other jurisdictions do not have a First Nations-specific strategy or model of care and are instead incorporating this into broader policies.
- Culturally safe healthcare delivery should ideally be driven by Aboriginal Health Practitioners and First Nations people, however cultural safety needs to be embedded across the health and justice systems. All health workforce require a baseline level of understanding and training in delivering culturally safe, trauma-informed care.
 - Maintaining a First Nations health workforce across the sector is very challenging, there is high attrition and a lot of vacant positions (not just in prisons). In prisons, it's very difficult to attract and retain staff in prison clinics due to the challenging setting, lack of cultural safety for staff, and uncompetitive salaries and benefits when compared to other public health services and ACCHOs.

Stakeholders suggested opportunities for reform...

- Consider embedding mandatory training for all health and corrections staff on cultural safety and trauma-informed care. This needs to be more than an on-line training module provided annually.
- Consider revising the national Aboriginal and Torres Strait Islander Health Workforce Strategy to include consider prisons health as a key focus area for development.
- Consider looking to ACCHOs and NACCHO standards, and work with First Nations people to design a culturally safe model of care for prison health care that can be tailored for specific locations.
- Consider evaluating current health services and programs to assess level of cultural safety and appropriateness for First Nations prisoners:
 - Greater consideration of social and emotional wellbeing in screening on entry which currently has a very Western medical approach to understanding health.
 - Explore innovative, alternative models of custody that enable prisoners with low security requirements to connect with their families and communities.

Access to trauma-informed mental health and alcohol and other drug (AOD) services was identified as major gap for people in custody

Stakeholders told us...

- First Nations people in prisons have more complex health needs than people in the general population and require access to comprehensive health and wellbeing services. Many prisoners do not have appropriate access to the supports required to meet their physical, psychological, social and emotional needs.
- Due to more complex needs, appointments with clinicians generally take more time, and require several follow-up appointments. Often these cannot be met by the existing service capacity, causing delays.
- There are varying degrees of screening for people entering custody, however often a limited capacity for appropriate follow up.
 - In particular, lack of access to therapeutic mental health services, trauma and grief counselling, along with services to address of there (often comorbid) conditions related to mental health and alcohol and drug use. These were identified as major service gaps in some regions.
 - Minimal screening for neurological conditions such as those relating to FASD and difficulties in completed screening processes for young people on remand.
- There is often a dis-incentive for people to seek mental health or AOD supports in prisons. This is driven by stigma, risks to reputation among the prisoner population and removal of certain privileges, such as access to employment and skill development programs.
- The provision of mental health and AOD services is often delivered by separate, specialist teams and are less likely to be delivered by First Nations providers. This can be an additional challenge for First Nations people who often do not feel comfortable accessing health care through a non-Indigenous provider.
 - For example, in the ACT, Winnunga Nimmityjah provide in-reach health services in custody however are not equipped to provide certain pharmacotherapeutic treatments (e.g. methadone replacement therapy). Their clients with AOD needs will are required to access this through mainstream prison services.

Stakeholders suggested opportunities for reform...

- Consider reviewing the screening mechanisms conducted on entry to better screen for trauma, grief, mental illness and neurodevelopmental conditions (incl. FAS-D), followed by the appropriate therapeutic services to support people with identified psychosocial challenges,
- Consider seeking a stronger understanding of international evidence and programs that support successful AOD programs in prisons to support a case for change
 - Particularly harm minimisation programs (e.g. needle and syringe programs).
- Consider examining evidence for therapeutic models of incarceration or alternatives to custody) that aim to address the health and wellbeing of people in custody.

People should be supported to make well-informed decisions relating to their health care

Stakeholders told us...

- Health literacy is a major barrier for prisoners when accessing and understanding their health care. Most prison health models rely heavily on self-presentation to prison clinics by either presenting to correctional officers or submitting a health request form. This requires a certain level of health literacy on the client's part and is especially difficult for people with cognitive disabilities or limited English skills.
 - In some states and territories, recall systems embedded in electronic medical records enable clinicians to know who to follow-up and when, instead of putting the onus on clients who may struggle to keep track of their health needs.
 - Clients also need to be supported to understand their medications, in terms of what they are prescribed and why. Stakeholders reported that clients are often handed their medications by clinicians with little explanation.
- First Nations prisoners should have the option to choose between mainstream health services or ACCHO-led services. Although stakeholders agreed the importance of First Nations people leading the delivery of health services to First Nations people in prisons, it was also raised that not all First Nations people choose to access ACCHOs in the community and should be offered the same choice when in custody,
- Language is another barrier for people in some regions, such as the Northern Territory, where a large proportion of First Nations people live in remote areas and do not speak English as their primary or even secondary language. Local translators embedded in services can better support people to have more decision-making capacity when it comes to their health care.
 - This also needs to be considered in paperwork to request health services, so that people with limited English skills can communicate their concerns via icons and imagery.

Stakeholders suggested opportunities for reform...

- Consider utilising electronic medical systems in all jurisdictions that enable patient recall notifications and link to pre- and post-incarceration.
- Consider establishing access to translator services in areas that have a high proportion of First Nations people with limited English (e.g. Northern Territory).
- Consider developing programs for people in custody to build health literacy.

There are significant barriers to maintaining continuity of care for people entering and exiting custodial settings

Stakeholders told us...

- There is significant disconnect between prison health services and community or public health services. A person entering the custodial system is viewed as a "new person" to the system,

without any link to their previous medical history or services accessed. This includes not only medical services, but services that support broader social and emotional wellbeing.

- A number of health assessments are available on entry to the custodial setting; however, onus is on that person entering the system to disclose all information they believe to be relevant to their health care. This presents a challenge for those who have lower levels of health literacy, or fear stigma or discrimination based on disclosure of certain medical information e.g. mental health issues or disability.
- In the case where multiple health services are offered within one setting, i.e. ACCHO service delivery within a prison, there may also be disconnect between the services internally. Variation in medical record keeping or information sharing protocols can present a barrier to effective continuity of care.
- The high churn of people through remand or short custodial sentences means that these people are much less likely to access the health care needed i.e. AOD treatment programs or high-cost pharmaceuticals. Given the shorter timeframe in which to deliver care, there is little opportunity to follow up the results of intake health assessments with the appropriate service.
- The transfer of inmates/detainees contributes to the disruption of care – in general, there is slow information exchange, duplication of health assessments, and breaks in health and wellbeing treatment programs.
- There are significant increased risks for people who leave custodial settings with higher rates of self-harm and suicide in the few years after release. These should be identified and managed like post-hospital care for people who have attempted suicide.

Stakeholders suggested opportunities for reform...

- Consider establishing and funding in-reach service arrangements by AMS and other community-controlled organisations to conduct health assessments on entry and exit.
- Consider arranging improved throughcare services for people transitioning from custody into the community, including better integration with social services upon return to the community.
- Consider embedding harm minimisation principles into throughcare services to support treatment and follow up for health care and AOD.
- Consider information sharing with public health and community services.
- Consider adopting previously effective models like the provision of a health passport as people leave with a follow up service/coordination provided.

Correctional facilities are a challenging environment for health staff to provide good quality health care

Stakeholders told us...

- Conflicting philosophies between health and justice make correctional facilities a challenging environment for health staff to work. Stakeholders reflected how security restrictions limited the degree to which health staff could provide client-centred care, which cut against the core

principles of health care. Access procedures and lockdowns also meant that health staff were unable able to provide care during periods of lockdown, nor can they leave prison premises until a lockdown period has ended. This restricted their personal freedom and was hugely disruptive to their ability to provide timely care.

- Stakeholders also reported that First Nations staff felt culturally unsafe in custodial settings.. Additionally, correctional facilities in remote and regional areas may be especially traumatic places to work as there is increased likelihood that people working in prisons will know or be related to people in custody.
- Custodial facilities were acknowledged to be difficult places to work, though there concern that there is an assumption all ACCHOs would have to provide health services to prisons (or at least those that are local to a correctional facility). It is important that ACCHOs are given the choice to provide services in prisons.
- In the ACT, Winnunga Nimmityjah staff recognise that as a condition of their role, they may be required to work in the Alexander Macochonie Centre (AMC) – although not everyone is rotated through the prison.

Stakeholders suggested opportunities for reform...

- Consider supporting leaders to promote culturally safe and supportive working environments for health staff.
- Consider reviewing security requirements to support access to health services and provide greater freedom to health staff where possible.
- Consider ensuring cultural safety training for staff is applied to the entire workforce, not just health staff.

4.5 Enablers

In almost all settings, the current workforce capacity and capability is not adequate to deliver culturally safe healthcare services

Stakeholders told us...

- Many jurisdictions reported difficulty in attracting and retaining health staff – particularly First Nations health workers and mental health workers. Custodial health services face challenges related to difficult working environments, lack of competitive pay and benefits, and competition with ACCHOs and other health organisations.
- The lack of representation and diversity within the health workforce limits the ability to deliver culturally appropriate health and mental health care in custodial settings.
- Most custodial staff are not fluent in culturally safe practices. Mandatory training exists in many jurisdictions but there is rarely ongoing support to implement culturally safe practices. Lack of cultural understanding creates an environment of tension and distrust between staff and First Nations people in custody, and affects how staff understand and respond to health requests.

- There is opportunity for custodial staff to increase their health literacy. Custodial staff often act as the 'gatekeeper' for health care – they are responsible for triaging prisoner health requests to health staff. However, custodial staff do not have the requisite knowledge to assess the health of prisoners. There have been serious incidents (and deaths) as a result of corrections officers not understanding the significance or severity of a medical incident or need.

Stakeholders suggested opportunities for reform...

- Consider developing workforce strategies and associated funding to build up a pipeline of health care workers into the future, for example through traineeships and other work experience pathways.
 - Including priority recruitment and support of First Nations health workforce
- Consider conducting trauma-informed cultural safety training for all staff within the custodial system.
- Consider conducting health training for corrections staff to increase awareness of health needs and better respond to health requests.

Inadequate information-sharing and outdated systems result in discontinuity of care and poorer health outcomes.

Stakeholders told us...

- All jurisdictions face difficulties in service integration and information sharing, particularly between:
 - Prison health and public health system – prison systems are not linked to public health systems, meaning records and other information is not readily available in custodial settings.
 - Prison health and community services – there is a lack of communication and information system integration with community services, particularly upon entry and release from custody, which limits continuity of care.
 - Between health and custodial staff – there are cultural and procedural barriers preventing adequate communication between health and custodial staff to the detriment of First Nations people seeking health care in custodial settings.
- Some jurisdictions still used paper-based record-keeping. This severely limits the ability for health services to access timely and comprehensive information on patients. This is especially challenging when patients are transferred between facilities as records are not available, resulting in duplicative health screening and assessments.
- Better data is needed to drive decision-making and accountability. Currently, there is no complete picture of healthcare delivery to First Nations people across jurisdictions.

Stakeholders suggested opportunities for reform...

- Consider employing digital information systems (electronic health records) that are linked to public health and community service systems.

- Consider utilising data from electronic health records to identify trends, risks and potential gaps in healthcare delivery within the prison system
 - Better data supports more accurate reporting and increased transparency.
 - Data-driven approach can inform policy decisions, resource allocations and program improvements for prison health services.
- Consider establishing secure telehealth services to enable better information sharing and connection with healthcare services external to the prison.

The provision of appropriate health infrastructure is a consistent gap in the ability to deliver culturally safe healthcare services

Stakeholders told us...

- Prisons are overcrowded and running over their intended capacity. Existing infrastructure is aging and no longer fit-for-purpose. Other facilities have been re-purposed but are not appropriately equipped to support healthcare delivery.
 - For instance, a Northern Territory prison was originally built as a men's prison but now has a women's section, which it was never designed for. Additionally, the prison health clinic is inside the prison walls but there are people in custody in cottages just outside the walls. It takes about 15 minutes for health staff to get in and out of the facility, making it very difficult to respond to emergencies (especially because people doing work in the cottages are practicing trade skills and are at greater risk of injury).
 - Additionally, ACCHOs reported not having access to facilities to provide appropriate health care. For example, Winnunga must provide health care in vacant prison cells, significantly limiting the quality of care they can provide.
- There are no standards for the design and construction of new prisons and clinics. Health facilities are seen as not being fit-for-purpose and do not cater to the needs of the people in custody.
 - There is no First Nations input into the design of new facilities to support culturally safe practices (despite making up a majority of the prison population in some areas, for example in the Northern Territory).

Stakeholders suggested opportunities for reform...

- Consider developing national standards include standards for health infrastructure within custodial facilities
 - Designed by people with health infrastructure expertise.
- Consider seeking input from First Nations communities to ensure facilities are fit-for-purpose, and support and accommodate cultural practices and beliefs related to health and healing whenever possible within the custodial environment.

- Consider ensuring infrastructure includes the provision of culturally appropriate resources, educational materials, visual aids, and signage.

Lack of funding was considered a key contributor to poor health delivery and outcomes for First Nations people in custody

Stakeholders told us...

- The lack of direct federal funding and limited state resources means that prisons lack sufficient resources to deliver comprehensive and timely health care. In most states this was financial resources, but there were also limitations in some areas where there are broader health workforce shortages and services are generally in limited supply.
- The exclusion of prisoners from access to Medicare within custodial settings is often equated to a restriction of human rights. Deprivation of liberty is the purpose of imprisonment, not a deprivation of health care.
- The exclusion from Medicare was considered inequitable as the Australian Government was funding other parts of the public health system, though not prison health services where there is greater need.
 - Stakeholders noted the lack of access to the Pharmaceutical Benefits Scheme (PBS) results in states bearing significant costs for medications. Cheaper forms of medication are often selected, which usually come with significant side-effects. Some medication is prohibitively expensive or unavailable outside of the PBS, inhibiting treatment of health conditions.
 - A key example given is the recent changes to the way which opioid dependence treatment is prescribed and funded – increasing the costs and administrative burden associated with delivery.
- Concern was also expressed that the granting of a 19(2) exemption may simply shift costs to the Australian Government and not lift the overall quality or access to care. The difficulties in attracting general practice into settings like aged care, for example, an area where Medicare access has not been sufficient to attract a workforce.
- The inclusion of Medicare services within a state-managed healthcare service may also bring complexity and operational issues and may not be the panacea to effective, culturally safe health care.

Stakeholders suggested opportunities for reform...

- Consider funding to meet need and support access to universal health care, inclusive of First Nations concepts of health and wellbeing including embedding the concept of choice into service settings.
- Consider provision of a s19(2) Medicare exemption for prison health services, for a limited set of items to increase continuity of care at reception and discharge. This would support funding of specific assessments and treatments – in particular, Aboriginal and Torres Strait Islander Health Assessments, GP sessions for transition planning and extended consultations on release.

- This exemption would also provide access to the Pharmaceutical Benefits Scheme, substantially lowering the costs of essential medications.
- Alternatively, consider developing a holistic funding model for high quality health services that meet the complex care needs of this cohort – including assessments, treatment, follow-ups and medication.
- Consider the potential of telehealth.
- Where services are being provided by ACCHOs with an existing 19(2) exemption, broadening this exemption to the prison setting would allow a wider range of services to be provided.

There are notable differences in the experiences and unmet needs of certain populations in custodial settings

For women:

- Women were identified to 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.
 - Women who give birth in prisons have their child immediately removed from their care. This is highly traumatic, especially given the history of Stolen Generations.
- The issue of dignity for women in prisons was raised multiple times, which has severe impacts on social and emotional wellbeing. For example, supervised showers, strip searches following family visits, limited access to sanitary products.
 - Women should have the option to see a female clinician, however the corrections environment is very male dominated.
- In some areas, women do not get access to the same job/skills development opportunities as men to support their release from prisons. In one example, women in custody are tasked with packing the breakfasts for the men's prisons.

For young people:

- Young people in detention experience disproportionately high rates of FASD and other neurodevelopmental conditions, however correctional staff are not trained to identify certain behaviours as a clinical symptom instead of defiance.
- There is a severe shortage of health workers in youth detention. Often young people are taken to outpatient services, however staff in these health services and emergency departments are less willing to provide care to young people who in custody.
 - Stakeholders reported that staff in external services were less likely to take the health needs of young people seriously 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.

- Driven by values of education, employment and community and supported – rather than led by security measures.

For people living with disabilities:

- Cognitive disability (diagnosed and undiagnosed) is severely overrepresented in the prison system, especially so for First Nations people.
- Stakeholders highlighted the prevalence of disabilities caused by external factors such as prolonged substance use and accidental brain injury from fights, accidents and failed suicide attempts.
- Undiagnosed cognitive disability was also flagged as a major risk factor for recidivism.
- Disability care is considered separate to health care, so often falls through the cracks between services provided by health and justice departments. Leaving people with disabilities without the supports they require.
- NDIS was raised as potential enabler for improving supports for people with disabilities in prisons and for reintegration following release.
- There is an opportunity for improved diagnosis for young people with disabilities in the prison system to support them to prevent recidivism after their release.

For people living with addiction:

- There is stigma around alcohol and drug use/dependencies in prisons. Prisons generally adopt a prohibitive model, rather than focusing on harm minimisation (as is done in the community).
- Some measures that may seem reasonable (e.g. smoke-free prisons) are driving people to seek more harmful drugs.
- Stakeholders reflected that it can be easier to access drugs in prisons than in the community.
- Programs within prisons are not the same as those that are available in the community (e.g. needle exchange programs)
 - There are severely high rates of Hepatitis C, other blood borne viruses (BBVs) and bacterial infections. First Nations people are disproportionately represented in these numbers.
- When in throughcare programs, drug use is a breach of bail conditions and can result in re-incarceration, even if the persons prior crime was unrelated to drug use.

5 Next steps

The Final Report will deliver a set of prioritised recommendations for reform to improve the health outcomes of First Nations people in custodial settings. Recommendations will be tested and refined with the Advisory Group prior to submission to the Australian Government. Figure 2 provides a high level overview of the delivery timeline for the Review.

Figure 2 Delivery timeline for the Review

