South Australian Prison Health Service

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH AND WELLBEING FOR SOUTH AUSTRALIA

November 2017

Final Report

Prepared by Wardliparingga Aboriginal Health Research Unit[1] for

– The South Australian Prison Health Service

– Central Adelaide Local Health Network

– SA Health

[1] Wardliparingga is a Unit within the South Australian Health and Medical Research Institute (SAHMRI)

SAHMRI South Australian Health & Medical Research Institute

WARDLIPARINGGA Aboriginal Research

Government of South Australia

This Report has been prepared for the SA Prison Health Services during 2017 by Wardliparingga Aboriginal Research Unit, SAHMRI.

The full report and an Executive Summary is available at https://www.sahmriresearch.org/Aboriginal-Prisoner-Health-Report

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ACKNOWLEDGEMENT OF COUNTRY

The key stakeholders of this project would like to preface this report with an acknowledgement of Country.

The Key Stakeholders of this project acknowledge the Kaurna people as the custodians of the Adelaide region and that their culture and heritage beliefs are still as important to the living Karna people today.

The key stakeholders of this project would also like to pay respects to the cultural authority of Aboriginal People from other areas of South Australia and Australia who have contributed to the development of this report and who will be involved in, or impacted by, the delivery of its recommendations.

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Minister's Foreword

I previously had the privilege of holding the portfolio responsibility for Correctional Services, in which we set an ambitious target to reduce re offending by 10 percent by 2020. As we strive to reach that target it is critical that wherever possible we break the cycle of imprisonment and tackle causes that result in reoffending, such as health and societal factors.

That is why this model of care is such an important piece of work specific to the health needs of the Aboriginal adult population in South Australian prisons.

With Aboriginal prisoners making up 22 percent of adult prisoners in South Australia, despite being only 2.3 percent of the total population, improving health outcomes in the prison environment can play a vital role in addressing offending behaviours.

With untreated chronic conditions, compounded by isolation from family and community and a fracturing in cultural identity and spiritual wellbeing, it is critical that access to good health care be a priority.

This can only be achieved in partnership with the Aboriginal community and Aboriginal specific health services.

Co-led by Aboriginal people for Aboriginal people, this evidence-based model of health care is a valuable collaboration between SA Health and SAHMRI. It aims to enhance clinical practice, inform and educate our workforce on cultural knowledge, and achieve life changing outcomes for Aboriginal prisoners which can be sustained long after they re-enter the community.

Cultural competence will become part of the health experience for Aboriginal prisoners, building on existing programs within the correctional system. This will see strengthened governance to ensure continuity of care with partnerships across SA Health, with the Department of Corrections and Aboriginal specific community based services.

This Model of Care provides a unique opportunity to make a significant contribution to the health and wellbeing of our Aboriginal Community and result in changing lives.

Successful change will only be made possible by maintaining strong partnerships and I acknowledge the significant contribution of the Aboriginal community to the development of this important Model of Care.

The Hon Peter Malinauskas MLC
Minister for Health
Minister for Mental Health and Substance Abuse

Preface

Adelaide Grannies Group

Many of our Aboriginal Elders have spent decades participating in forums and workshops regarding the incarceration of our young people and the issues of over-representation and underutilisation of resources in addressing our Aboriginal youth, men and women who are in prison. For many years Governments have explored key issues, and directives have been developed to investigate the causes of why Aboriginal people end up in the justice system, but to date, the Elders feel that they have not really found an answer or solutions to decrease our people being incarcerated.

The pain and anguish many of our Elders have suffered because of our sons, daughters, and our youth being put into prison, leaving them isolated and without any connection to their families and communities, is profound. Each family is affected by their people being incarcerated, and not being able see or speak to them adds to the aching of our heart. We have felt that the justice systems have failed to address the broad social context and have not provided the supports for our people while in prison nor when released.

However, the Elders believe that no matter how long it takes we must continue to search for solutions and to make changes for our people who are incarcerated. Working alongside Wardliparingga at the South Australian Health and Medical Research Institute will ensure our 'voices' are heard.

The objective of this research was challenging for us and we had to discuss many of the complex health needs of our community. By exploring different stakeholders' points of view and sharing what kind of 'model of care' we could design to address the broad needs of Aboriginal adult prisoners, highlighted the need for qualitative research that would give us the opportunity to inform policy and practice.

We have concluded the research and it has produced the South Australian Model of Care for Aboriginal Prisoner Health and Wellbeing. Our Elders hope that this model of care will be taken seriously by Governments, and that Stakeholders will make it their business to participate and implement changes, for the betterment of our Aboriginal adult and youth prisoners in South Australia.

Pat Waria-Read,
Representative Elder Visitors Program
Heather Agius and Evelyn Varcoe,
Representatives, Adelaide Grannies Group

SA Health

This collaboration and the resulting valuable piece of work has come about as a consequence of SA Health, in particular SA Prison Health and Watto Purrunna (the Aboriginal Primary Care Services for Northern Adelaide LHN), seeking an evidence-based model of care specific to the health needs of the Aboriginal adult population in SA Prisons. It was quickly established that not much existed so Wardliparingga, the Aboriginal Health Research Unit at the South Australian Health and Medical Research Institute (SAHMRI), was approached to assist in designing an evidence-based model of care.

The engagement of Wardliparingga was a decisive move to acknowledge that Aboriginal research is done best when in the hands of Aboriginal people. This work is so important to saving lives. Every opportunity should be embraced to make a difference and although many great thinkers have gone before us, this we believe is different. Critical partners have joined hands and worked to the guiding principles of the South Australian Aboriginal Health Research Accord; these are: to be led by Aboriginal priorities, Aboriginal involvement, Aboriginal partnership, respect for culture, communication, reciprocity, Aboriginal ownership, Aboriginal control and Aboriginal knowledge translation. To make this happen, a reference group was formed to govern the project with representatives from SA Prison Health, the Department of Correctional Services, Watto Purrunna, The Grannies Group and the DCS Elders visiting program.

SA Prison Health are one of the few services that have daily contact with most prisoners, along with correctional officers, and know first-hand the over-representation of Indigenous people in prisons. Although there are not many upsides to incarceration, staff have always recognised it as an important opportunity, in fact a vital one, to improve Aboriginal health and wellbeing with aspirations that they leave in better health than when they arrived. It is also a chance to address those issues that might well have led them to be there in the first place. Prison health and correctional staff witness first-hand the travesty of Aboriginal incarceration and devastation to individuals, families and whole communities that locking up Aboriginal people creates. The whole is greater than the sum of its parts, therefore together in partnership Health and Corrections can make a real difference.

Let this be the beginning of real change in honour and recognition of those lives that have already been lost or damaged. SA Health would like to acknowledge the strong leadership and passion from within the Aboriginal community, the Department for Correctional Services and Watto Purrunna and their ongoing commitment to take this and many more steps that are needed to make that difference. Whilst acknowledging the challenges to its implementation, it is with great expectancy that I endorse this Model of Care for Aboriginal Prisoner Health and Wellbeing for implementation.

Vickie Kaminski, *Chief Executive, SA Health*

SA Department for Correctional Services

The Department for Correctional Services strongly supports the development of a model of care for Aboriginal prisoners in South Australia and was pleased to be engaged in the consultation process. The overrepresentation of Aboriginal people in custody is of deep concern to anyone involved in the criminal justice sector. Coordinated, collaborative responses are essential to address the complexities that Aboriginal people in our custody present with. We are committed to working in strong partnership with the Department of Health - predominantly the South Australian Prison Health Service and the Forensic Mental Health Service to better target and coordinate the health responses for Aboriginal people. Health and wellbeing are critical components of any framework to reduce reoffending and incarceration rates.

Mr David Brown, *Chief Executive, Department for Correctional Services*

Acknowledgements

Project Governance Reference Group

The project team wishes to acknowledge with gratitude the valuable contributions of members of the Project Governance Reference Group, who met monthly to guide this project. The Project Reference Group wishes to acknowledge the input from staff of the Prison Health Service and Department of Corrections as well as the participation of Aboriginal prisoners, their families and advocates.

Kurt Towers	Chair, Director Aboriginal Health Services, Central and Northern Adelaide Local Health Network
Auntie Heather Agius	Elder Representative, Grannies Group
Tricia Cash*	Manager Operations, SA Prison Health Service
Scharlene Lamont	Director Aboriginal Services, Department for Correctional Services
Danielle Lovegrove	Aboriginal Health Worker, Northern Adelaide Local Health Network
Lee MacDonald*	Manager Offender Development Unit, Department for Correctional Services
Alan Scarborough*	Director of Nursing, SA Prison Health Service
Crystal Sumner	Manager Aboriginal Services, Department for Correctional Services
Joel Tessman	Aboriginal Health Worker, Northern Adelaide Local Health Network
Auntie Evelyn Varcoe	Elder Representative, Grannies Group
Auntie Pat Waria-Read	Elder Representative, DCS Elder Visitors Program
Andrew Wiley*	Nursing Director, SA Prison Health Service

Wardliparingga Aboriginal Research Unit

Project Team:

Harold Stewart	Project Lead/Senior Cultural Advisor
Luke Cantley	Project Officer (SA Prison Health Service)
Leda Sivak*	Senior Project Officer
Kathy Mott*	Contract Manager

Advisory Group

Professor Alex Brown	Consultant (Theme Leader, Aboriginal Research, SAHMRI)
Adrian Coulthard	Clinical Consultant (Aboriginal Health Practitioner)
Dr Karen Hawke	Consultant, communicable diseases prevention and management
Dr Janet Kelly*	Consultant, health services quality, workforce, education and training
Andrea McKivett	Clinical Consultant (medical doctor)
Waylon Miller	Clinical Trainee
Shereen Rankine	Clinical Consultant (RN)
Dr Rachel Reilly*	Clinical Consultant (Psychologist)

**Denotes non-Indigenous team member*

The project team would also like to acknowledge the broader Wardliparingga team for supporting this project.

1. Executive Summary

1.1. Introduction

Aboriginal people within prisons have complex health needs. The isolation from family and community, compounds the profound intergenerational trauma, associated unresolved grief and loss, and resulting mental illness and other chronic health conditions, such as diabetes, heart and respiratory diseases, cancer and substance misuse disorders. This makes the care of Aboriginal prisoners challenging, and therefore needing careful consideration and management in terms of risks to their health and wellbeing while in prison.

The objective of the SA Prison Health Service (SAPHS) was to design a model of care that attends to the broad needs of the Aboriginal adult prisoner population (male and female) within the nine adult prisons across South Australia.

The project used a qualitative mixed method approach. Methods included:

1. Rapid review of relevant literature
2. Stakeholder consultations
3. Stakeholder workshop

The definition of model of care used by the project team was:

"*…an overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, evidence-based practice, and defined standards. It consists of defined core elements and principles and has a framework that provides the structure for the implementation and subsequent evaluation of care.*" *(Davidson et al 2006: 49)*

1.2. The Literature Review and Stakeholder Consultations

There is little published literature regarding models of care for Indigenous prisoner health, within Australia or internationally. There were two Australian publications and one international publication of interest.

The only published Australian model of care for Aboriginal prisoner health was the Winnunga Holistic Health Care Prison Model (Winnunga Model). This is an in-reach model designed to address the needs of prisoners and ex-prisoners and their families, and to manage the cycle of incarceration both within and outside of the prison setting.

The Victorian Aboriginal Community Controlled Health Organisation produced a report exploring prison health services in Victoria to improve quality, culturally appropriate, care for Aboriginal people inside, and after release from, Victorian prisons (Halacas and Adams 2015)

The Northern-Midland Region Prison Model of Care for Serious Mental Illness (PMOC 2011) was developed to improve the consistency and quality of prison mental health in-reach care in the northern part of New Zealand.

The stakeholder consultations identified key themes that informed many of the components of the draft model of care. Priority conditions identified during the consultations included: gender-specific needs; chronic conditions; mental illness; communicable diseases; substance misuse disorders and disability. Core Elements identified during the consultations included: pre-release planning; culture, spirit, and identity; communication; access and continuity; family; flexible pathways; recovery, rehabilitation, therapeutic services; and patient linked to community services prior to release.

The findings of the stakeholder workshop directly informed the final overarching design and detailed framework for the model of care.

1. Executive Summary (cont.)

1.3. The SA Aboriginal Prisoner Health and Wellbeing Model of Care

The Model of Care for Aboriginal Prisoner Health and Wellbeing has the following components:

1. Overarching design
2. Theoretical basis with principles
3. Evidence base
4. Standards
5. Core elements
6. Key considerations

The Model of Care for Aboriginal Prisoner Health and Wellbeing is holistic, person-centred, and underpinned by the provision of culturally appropriate care. It recognises that Aboriginal prisoners are members of communities both inside and outside of prison, and that released into the community at the completion of their sentences needs consideration. It notes the unique needs of remanded and sentenced prisoners and differing needs by gender.

The South Australian Aboriginal Prisoner Health and Wellbeing Model of Care draws on the theoretical framework of the Winnunga Holistic Health Care Prison Model (Winnunga Model). It also draws on the key principles of the Northern-Midland Region Prison Model of Care.

The principles that guide the Model are in the areas of: (1) human rights and treatment of prisoners; (2) anti-racist prison cultures; (3) people-centred and responsive to family; (4) compulsory mental health care; (5) treatment and recovery paradigm; (6) community equivalence of care; (7) social and emotional wellbeing in prisons; and (8) reducing recidivism.

The model has eight core elements: (1) pre-release planning begins at entry to prison; (2) culture, spirt and identity; (3) communication; (4) access and continuity; (5) family; (6) flexible pathways; (7) recovery, rehabilitation, therapy; and (8) prisoner is linked to community-based services pre-release.

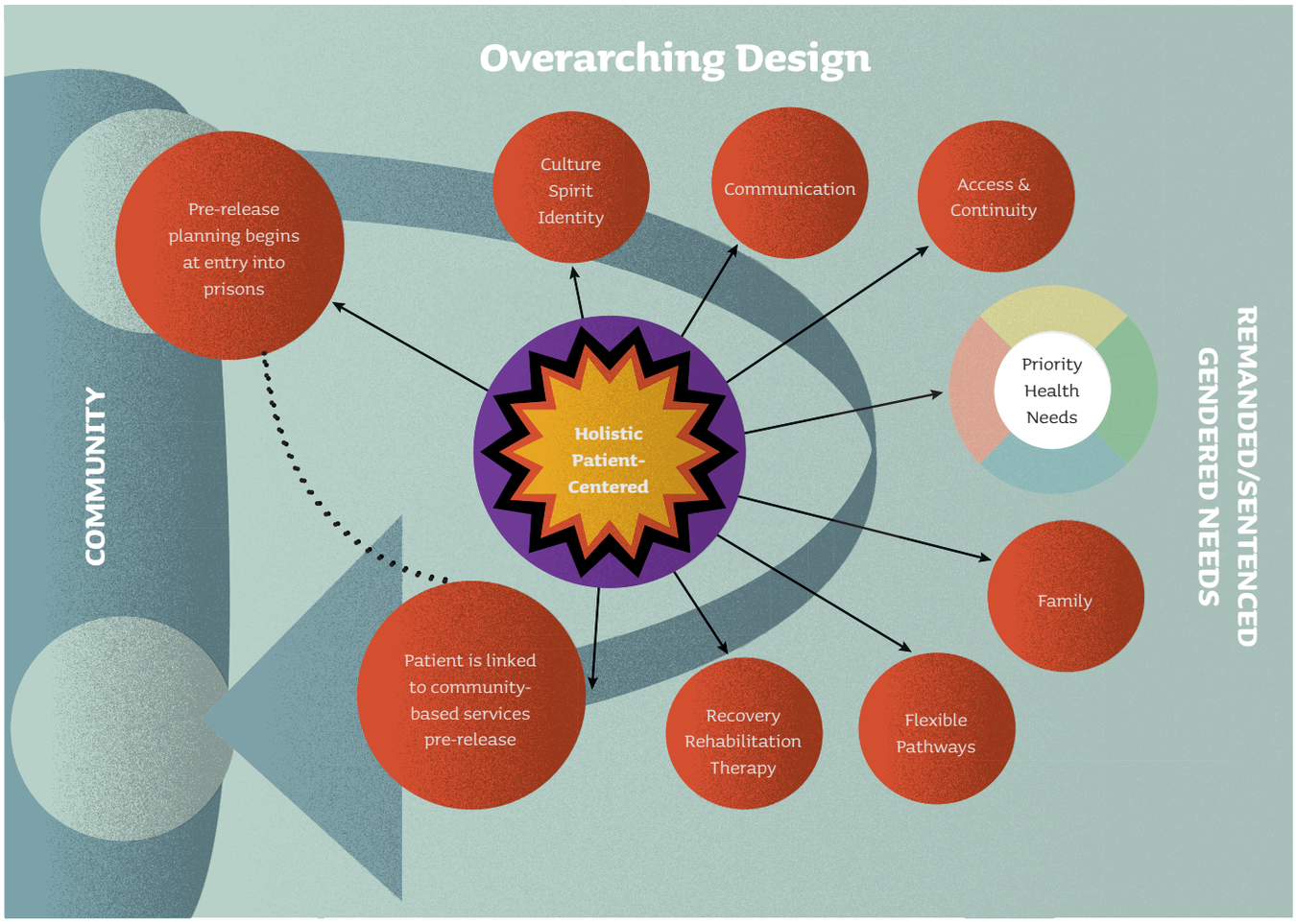

Figure 1 The SA Aboriginal Prisoner Health and Wellbeing Model of Care

1.4. Recommendations

1. It is recommended that the SAPHS adopt the SA Aboriginal Prisoner Health and Wellbeing Model of Care and plan for its implementation during 2018.

Governance and accountability

2. Develop a joint SAPHS/DCS governance structure and implementation plan for the Model of Care, including appropriate input from LHNs, Aboriginal community representatives such as Elders, advocates and former prisoners.
3. Develop a detailed monitoring and evaluation approach for measuring the impact and outcomes of the Model of Care.
4. Develop appropriate cost sharing between Central Adelaide Local Health Network and Country Health SA Local Health Network to ensure access and continuity of care, flexible pathways, therapeutic mental health care and links to community services.

Workforce and training

5. Establish a strategy to ensure a gender-and culturally diverse Prison Health Service workforce to provide culturally appropriate care to all Aboriginal prisoners.
6. Work with relevant LHNs and appropriate ACCHOs to implement an Aboriginal Health Practitioners in-reach program in the short-term, with a goal to achieve a workforce that includes Aboriginal Health Practitioners (within the SAPHS and from external agencies) at all South Australian prisons within 5 years.
7. Deliver ongoing cultural awareness and cultural competency training for all SAPHS and DCS staff within South Australian prison facilities; such training needs to be both general in nature and specifically tailored to local community connections and culture. This would include a state-wide consistent approach that is designed by Aboriginal people skilled and experienced in the delivery of such training. Involvement of local community in ongoing cultural training would be encouraged.
8. Ensure SAPHS and DCS staff have training and awareness of racism as impacting on health and wellbeing.
9. Ensure all Prison Health Service and Correctional Services staff have access to regular briefings/updates on the specific health needs, emerging issues and evidence and associated care requirements of Aboriginal people in South Australia.
10. Provide training and support for SAPHS and prisoners to use existing technologies (e.g. MyGov) to track health care and other services and entitlements.

Interagency links

11. Strengthen formal and operational links between prisons and their local community healthcare services, including Aboriginal Community Controlled Health Services and ensure staff are aware of the local primary care and other specialist health services that prisoners may need for ongoing care after release into the community.
12. Ensure staff who facilitate release of prisoners are aware of the health needs of the prisoner upon release and are able to access information on agencies such as housing, transport and social services in the post-release setting to improve pre-release planning from entry and direct patients to community services.

Pre-release planning begins at entry into prison

13. Review the initial assessments of health needs conducted on entry of all Aboriginal people into prison/remand, to ensure a comprehensive medical and wellbeing assessment is able to be conducted. The review would assess current processes, capacity, systems, and workforce and map a planned approach to reaching a “best-practice” approach to assessment, care planning and health and wellbeing management and support.
14. Review current practices for release of Aboriginal prisoners as it relates to transition of their health care to a primary care service/practitioner. Effective transition will require coordination across SAPHS, DCS and relevant community based and in-reach social and health services from first entry to prepare for return to community.

1. Executive Summary (cont.)

Culture, spirit identity

15. Establish a Working Group to consider and make recommendations on the recognition, active support and strengthening of cultural identity and spiritual health of Aboriginal prisoners. This would involve consideration of: spiritual health cultural care, kinship care, Ngangkari and other Traditional Healer services, grief and loss support, healing circles and peer support between prisoners and by Aboriginal health and support staff.

Communication

16. Develop a program of health literacy improvement amongst Aboriginal prisoners to improve prisoners' understandings of their diagnoses, decisions and processes of care and support self-management.

17. Ensure appropriate interpreter services are available in all prisons to assist SAPHS staff with promoting better understanding and compliance with treatments for Aboriginal prisoners for whom English is not spoken or is a second language.

Access and continuity

18. Extend eligibility criteria for all health services and programs to Aboriginal prisoners on remand or with short-term sentences.

19. Ensure information is sought from prisoners about their usual primary care service/practitioner to improve access to prisoner's pre-prison health and mental health histories and for appropriate transition after release.

20. Support a DCS review the current system of prisoner movements and their impact on disruption to a person's privileges (e.g. cellmate, job, security rating, etc.) while accessing health care externally.

Family

21. Develop a procedure for improved communication of vital health information to family members as soon as is practicable (e.g. hospital visits), taking into account privacy issues and practicalities.

22. Consult with Aboriginal prisoners and community members regarding improved support for grieving, especially for prisoners who cannot attend family events or funerals.

23. Develop appropriate facilities within prisons to support parenting, including parenting education and other practical programs that maintain parenting skills

24. Consult with Aboriginal women in the community and prisoners regarding advocacy for prison alternatives for women who may have to give birth in prison

Flexible pathways

25. Establish facilities in all prisons to support the use of telehealth and videoconferencing for Aboriginal prisoners to access specialist assessments, treatments and care and avoid unnecessary, costly and disruptive transfers.

26. Increase the number of in-reach programs, especially to form links with primary health and to provide therapeutic services for alcohol and other drug misuse mental illness, domestic and family violence and other trauma.

Recovery, rehabilitation, therapy

27. Investigate, plan and implement a comprehensive therapeutic mental health care service within the SAPHS, using the New Zealand Model of Care as a reference point, ensuring cultural appropriateness for the Aboriginal prisoner population and including:

a. Brief mental health interventions for people on short-term sentences and remand.

b. Increased opportunities for mental health maintenance including meaningful activities and vocations.

28. Prepare and implement a chronic and communicable disease strategy for primary and secondary prevention, ongoing self-management, evidence-based health support (including structured physical activity and nutritional dietary options) and high quality medical and allied health services for prisoners with heart disease, diabetes, respiratory conditions, kidney disease, communicable diseases and common mental illnesses.

29. Prepare and implement disability support programs through the use of physiotherapists, occupational therapists and exercise physiologists and ensure daily care needs can be met for Aboriginal prisoners with day to day care needs.

Prisoners linked to community based services pre-release

30. Develop systems and procedures to ensure relevant medical records, medications and links to community services are prepared for all prisoners prior to court hearings to facilitate effective transition of health care and wellbeing if prisoners are released off-Court including development of a checklist to cover:

    a. Entitlements - Medicare number and card, Centrelink status

    b. Access to finances

    c. Access to medications, including contraception

    d. Contacts for primary health care and specialist support

    e. Housing

    f. Transport

1.5. Conclusions

The South Australian Model of Care for Aboriginal Prisoner Health and Wellbeing has been prepared with the participation of all stakeholders through a process of referencing international evidence, and grounding the model within both a theoretically sound and culturally sensitive framework. It has the flexibility to take account of local prison ways of working and prison populations.

The Model of Care provides the basis for enhancing the current Prison Health Service and prison systems to better support the health and wellbeing of Aboriginal prisoners. The Model is consistent with the Department for Correctional Services Strategic Policy Panel Report, Reducing Reoffending – 10% by 2020 (DCS 2016). Importantly, the Model of Care, if implemented would also contribute to addressing some of the recommendations of the Royal Commission into Aboriginal Deaths in Custody, still relevant 26 years after its completion

2. Introduction

2.1. Background

In late 2016, Mr Kurt Towers, Director, Aboriginal Health for Central (and Northern) Adelaide Local Health Networks, approached Wardliparingga Aboriginal Health Research Unit (Wardliparingga) at the South Australian Health and Medical Research Institute (SAHMRI), to discuss the development of a model of care to address the health needs of Aboriginal people in South Australian prisons.

Healthcare for Aboriginal prisoners is provided by SA Prison Health Service, an organisational unit that sits under Central Adelaide Local Health Network. Prisons are operated under the Department for Correctional Services.

In 2016, the twenty-sixth anniversary was reached for the findings of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991). It is important to consider the work that has been undertaken to develop this model of care for Aboriginal prisoners in SA, within the context of the findings[2].

"…generally speaking the standard of health of the ninety-nine varied from poor to very bad (the average age of those who died from natural causes was a little over thirty years); their economic position was disastrous and their social position at the margin of society; they misused alcohol to a grave extent (of the twenty-two deaths by hanging in police cells, nineteen at death had a blood alcohol level of 0.174 per cent or over, mostly much over) and, of the other three, one level was not taken and one was suffering severe withdrawal symptoms)." (RCIADIC 1991: 1.2.17)

Although 26 years ago, the picture of the health of Aboriginal people in prison remains similar in 2017. Aboriginal people generally will have more serious health conditions at younger ages and those who encounter the prison system are likely to be no different. In fact, many Aboriginal people within prisons have more complex health needs than the wider Aboriginal population within South Australia. The combination of isolation from family and community, compounds the profound intergenerational trauma, associated unresolved grief and loss, and resulting mental illness and other chronic health conditions, such as diabetes, heart and respiratory diseases, cancer and substance misuse disorders. This makes the care of Aboriginal prisoners complex and challenging, and therefore needing careful consideration and management in terms of risks to their health and wellbeing while in prison.

Equally, while in prison, "under the care and protection of the State" there is a significant opportunity, and indeed, obligation, for authorities to provide the best possible healthcare to those prisoners who are most vulnerable. Supporting SA Prison Health Service and Department for Correctional Services staff to provide the best possible care for Aboriginal prisoners is imperative.

"….. there are in place a large number of agencies, departments etc. with operations in areas of considerable Aboriginal population. But the staff are not, in many or most cases, given any special training to enable them to provide an appropriate or the most appropriate service to the Aboriginal clients. The recommendations, associated with different service areas are directed to this question. I make it clear that I do not envisage those staff members being trained to be amateur anthropologists; but that they be trained in cross cultural communication and sensitivity, and in something of the history and circumstances of the local Aboriginal people and the history of race relations in the area." (RCIADIC 1991: 1.10.4)

The project began in January 2017 and was completed on 30 June 2017.

2.2. Project Brief

Wardliparingga was engaged by the South Australian Prison Health Service (SAPHS) to design a model of care that attends to the broad needs of the Aboriginal adult prisoner population (male and female) within the nine adult prisons across South Australia.

Negotiations between SA Health and SAHMRI determined the scope of the work to be undertaken. It was agreed that the model of care would take account of the following key matters:

- The Aboriginal workforce within SAPHS, including the potential for introducing Registered Aboriginal Health Practitioners;
- Needs of the Aboriginal prisoner population including specific needs of certain subpopulations such as young women, people with substance misuse issues or addictions, people with infectious diseases, people with chronic health conditions, people with terminal illnesses;
- Priority health issues, with reference to the SA Aboriginal Heart and Stroke Plan 2017-2021, SA Aboriginal Diabetes Strategy 2017-2021 and SA Aboriginal Cancer Control Plan 2016-2021;
- Referral pathways within SAPHS and to external agencies;
- Scopes of practice of certain health workers/practitioners; and
- Resource availability.

This report outlines the methods, results of the study, and details of the proposed model of care. Although implementation of the model is beyond the scope of the project, this report also makes several key recommendations to assist SAPHS to begin planning for implementation of the model.

[2] Quotes from the Final report of the Royal Commission were accessed at: http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol1/9.html

3. Approach

The Wardliparingga team designed an approach to meet the needs of SAPHS, which included ethical practice, clear project governance, a diverse and appropriately skilled project team, and suitable methods to provide an evidence-based model of care.

3.1. South Australian Aboriginal Health Research Accord

As a signatory to the South Australian Aboriginal Health Research Accord (the Accord), all SAHMRI projects must adhere to the nine principles of the Accord, which include: Aboriginal priorities, involvement, partnership, respect, communication, reciprocity, ownership, control and knowledge translation. A table describing how the South Australian Aboriginal Prisoner Health and Wellbeing Model of Care project addressed the principles of the Accord is presented in Appendix 1. This table includes expected actions that were identified at the beginning of the project, as well as a final review at its completion.

3.2. Project Governance

The project was overseen by a Stakeholder Reference Group, which met monthly to ensure that the specific needs of project partners, stakeholders and communities were appropriately incorporated into the planning and management of the project and to facilitate access to relevant information and key informants for the project. The Reference Group members included Central Adelaide Local Health Network (CALHN), SAPHS, Department for Correctional Services (DCS), Grannies Group, Aboriginal Health Practitioners (AHPs) and selected members of the Wardliparingga project team, as per the diagram below (see *Figure 2*).

Figure 2
Stakeholder Reference Group members

3. Approach (cont.)

3.3. Methods

The project used a qualitative mixed methods approach. Methods included:

4. Rapid review of relevant literature

5. Stakeholder consultations

6. Stakeholder workshop

In addition to the stakeholder consultation, the project was also informed by two other activities. First, CALHN engaged with selected prison sites to scope an Aboriginal Health Practitioner in-reach program. Second, SA Prison Health Services conducted consumer engagement activities with current prisoners, the findings of which contributed to the analysis of other findings. The project components and the relationship to the other two activities are summarised in the diagram below (see *Figure* 3).

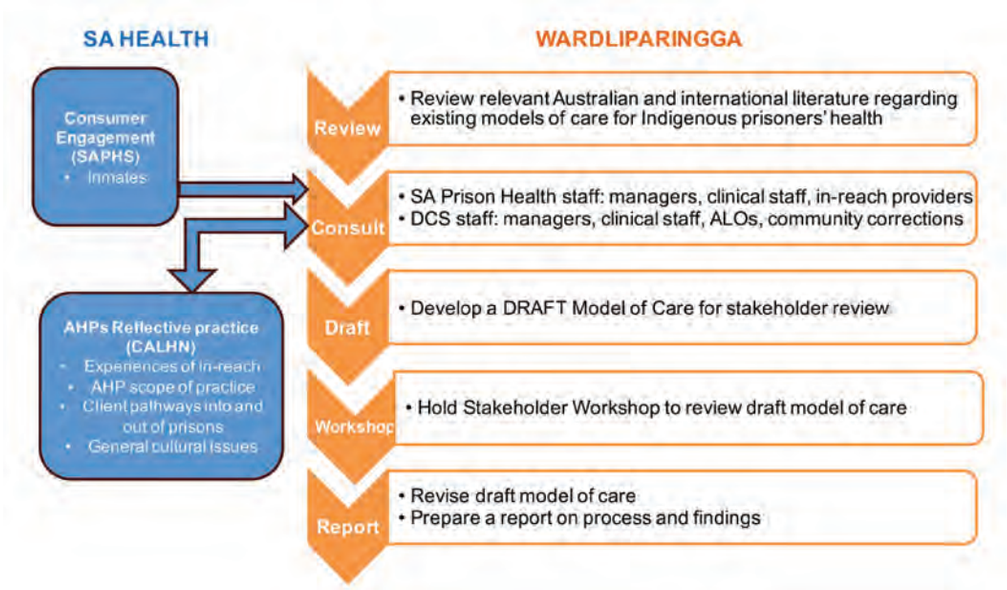

Figure 3 Summary of project method, components and activities.

A description of each of these steps is provided within this Methods section, while key findings from each of the steps will be provided within the Findings section which follows.

Review of Literature

The project team reviewed the published and grey literature regarding models of care for Indigenous prisoner health, both within Australia and internationally. As there were very few published models which met the inclusion criteria, the project team searched more broadly in order to understand the evidence base regarding Indigenous prisoner health and to identify contemporary approaches to address priority health needs. While a summary of the findings of the review of models of care is presented in the Findings section, details of the additional evidence reviews are presented in Appendix 5.

Consultation

As noted in *Figure* 2 above, the consultation phase of this study comprised three components: (1) stakeholder consultations as per the contract; (2) consumer engagement undertaken by SAPHS; and (3) reflections from the Aboriginal Health Practitioner in-reach pilot. The methods for each of these is provided here, while findings from the consultations are presented in the Findings section below.

Stakeholder Consultation

The formal stakeholder consultations for this project began on Wednesday 26 April 2017 and finished on Friday 12 May 2017. Stakeholder consultations included conversations with SAPHS and DCS staff at eight of the nine adult prison facilities in South Australia regarding: priority health needs of Aboriginal patients, current practice, existing referral pathways and anticipated workforce needs. Mount Gambier Prison was not included in the consultations as it is privately run and does not use the services of SAPHS for health care provision. In addition to the formal consultations, the Project Manager and Project Officer also met with the Grannies Group and the DCS Aboriginal Elders Visiting Program members in February and March 2017. Consultation dates and numbers of people consulted are shown in *Table 1* below.

Date	Location	Aboriginal Community	Health	DCS
20 Feb	Grannies Group	7 x Elders	--	--
10 March	Pt Augusta	--	1x NUM 7x Nurses	1xGM 1xALO 2xSW
31 March	Elders Visiting	9x Elders	--	--
4 April	Nurse Managers	--	9x Nurses	--
26 April	Remand Centre	--	9x Nurses	1x MOD
27 April	Port Lincoln	6x Prisoners	6x Nurses	1xA/GM
1 May	Cadell	--	5x Nurses	1x MOD
8 May	Yatala	--	12x Nurses	2x ALO, MOD
9 May	Pt Augusta	--	1x NUM	2x ALO, MOD
9 May	Women's	6x Prisoners	--	--
10 May	Mobilong	--	11x Nurses	2x ALO
12 May	Women's Pre-release	(See above)	1x NUM	1x MOD
TOTALS: 103 People		**12x Prisoners** **16x Elders**	**61x Health**	**14x DCS**

Legend: NUM = Nurse Unit Manager; MOD = Manager for Offender Development; GM = General Manager; A/GM = Acting General Manager; ALO = Aboriginal Liaison Officer.

Table 1 Stakeholder consultation dates and people consulted

Furthermore, although not shown in the table above, pre-consultation visits were undertaken by the Project Officer at several prisons (i.e. Port Augusta Prison, Yatala Labour Prison, Cadell Training Centre, Mobilong Prison) in advance of the formal consultation phase in order to introduce the study and facilitate consultation scheduling.

Consumer Engagement

As shown in Table 1, consumer engagement activities were undertaken with twelve Aboriginal 'consumers', that is, six male Aboriginal prisoners at Port Lincoln Prison and six female Aboriginal prisoners at Adelaide Women's Prison. For these activities, the Project Officer was accompanied by the SAPHS Manager for Consumer Engagement, who prepared a report for SAPHS. The Project Officer's reflections on the data from the consumer engagement activities informed the consultation findings, particularly by mapping one patient journey to illustrate the impacts of SAPHS policies and procedures.

3. Approach (cont.)

Reflections of Aboriginal Health Practitioner In-reach Pilot

There were delays in starting the in-reach pilot. However, the Project Manager and Project Officer shared their reflections from engaging with various prison settings and staff with the Northern Adelaide Local Health Network (NALHN) and CALHN staff to share understandings about the current workforce, care practices and variations between sites.

Drafting the Model of Care

At the completion of the consultation, the Wardliparingga team drafted a model of care based on the findings of the evidence review and consultations. The definition of model of care that was used by the project team was:

"*…an overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, evidence-based practice, and defined standards. It consists of defined core elements and principles and has a framework that provides the structure for the implementation and subsequent evaluation of care.*" *(Davidson et al 2006: 49)*

This definition can be visualised as per the diagram in *Figure 4* below.

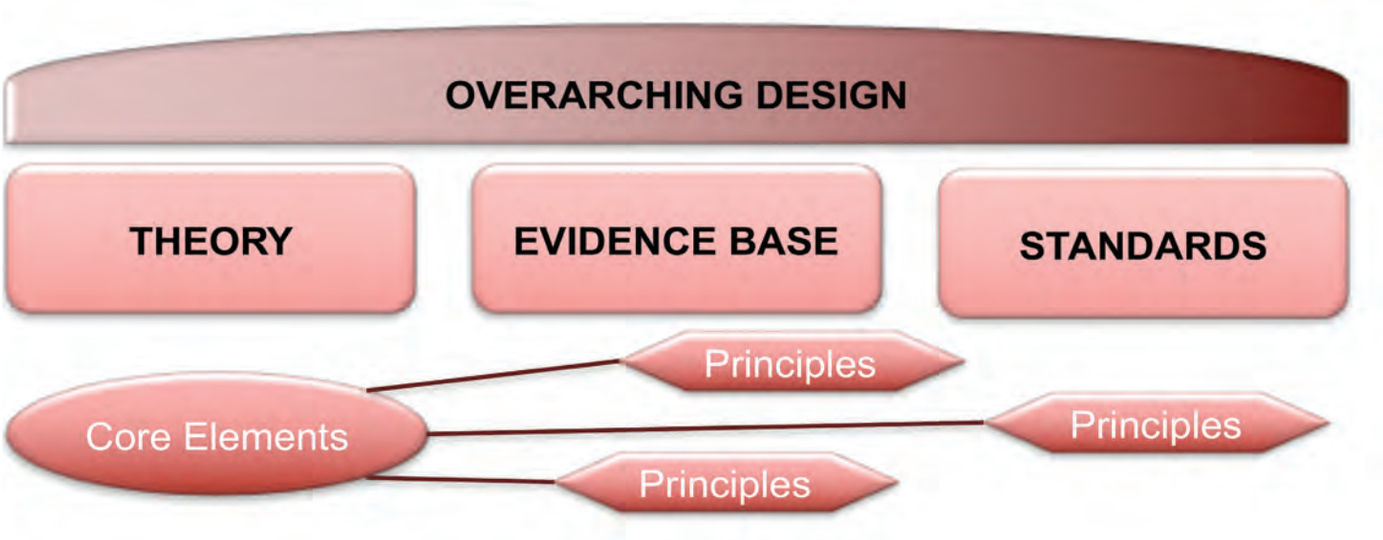

Figure 4 Diagram illustrating a definition of model of care.

The process of drafting the model involved a series of meetings with different combinations of the project team in order to test and revise the model before emailing the draft model to potential participants one week prior to the Stakeholder Workshop. Because of the tight timeframes, the team continued to adjust and modify the draft model right up to the day of the Stakeholder Workshop.

Stakeholder Workshop

A Stakeholder Workshop was held on Monday 5 June, 12:30-4:00pm at SAHMRI Auditorium, North Terrace, Adelaide. Invitations were extended to key representatives from the following organisations:

- Aboriginal Elders Visiting Program
- Aboriginal Health Council of South Australia
- Aboriginal Prisoner and Offender Support Services
- Australian Nursing and Midwifery Federation
- Central Adelaide Local Health Network
- Commissioner for Aboriginal Engagement
- Country Health South Australia Local Health Network
- Department for Correctional Services
- Director Forensic Mental Health
- Grannies Group
- Health Services Union
- Life Without Barriers
- Mount Gambier Prison
- Northern Adelaide Local Health Network
- Office of the Chief Psychiatrist
- Public Services Association of South Australia
- South Australian Prison Health Service
- South Australian Salaried Medical Officers Association
- Southern Adelaide Local Health Network
- Street to Home Service
- Women's and Children's Health Network

The draft model of care was emailed to those registered to attend one week prior to the Stakeholder Workshop to give participants time to consider the draft before the event. The purpose of the workshop was to engage frontline stakeholders directly in reviewing and contributing to the draft model of care. This involved three main tasks:

1. Describing the study and introducing the draft model of care.
2. Asking participants to identify strengths of the draft model of care, and key issues that the project team may have missed.
3. Considering enablers and barriers to implementing a state-wide model of care for Aboriginal prisoner health.

Activities associated with these tasks included three workshops:

1. ***Workshop One: Validating the model –*** groups were asked to discuss the model as a whole; in particular:

a. Does the visual model adequately communicate the layers that were described in the presentation?

b. Are all the core elements vital to the model of care?

c. Has the project team missed anything that needs to be included?

The draft model that was used for this workshop is shown in *Figure* 5 below.

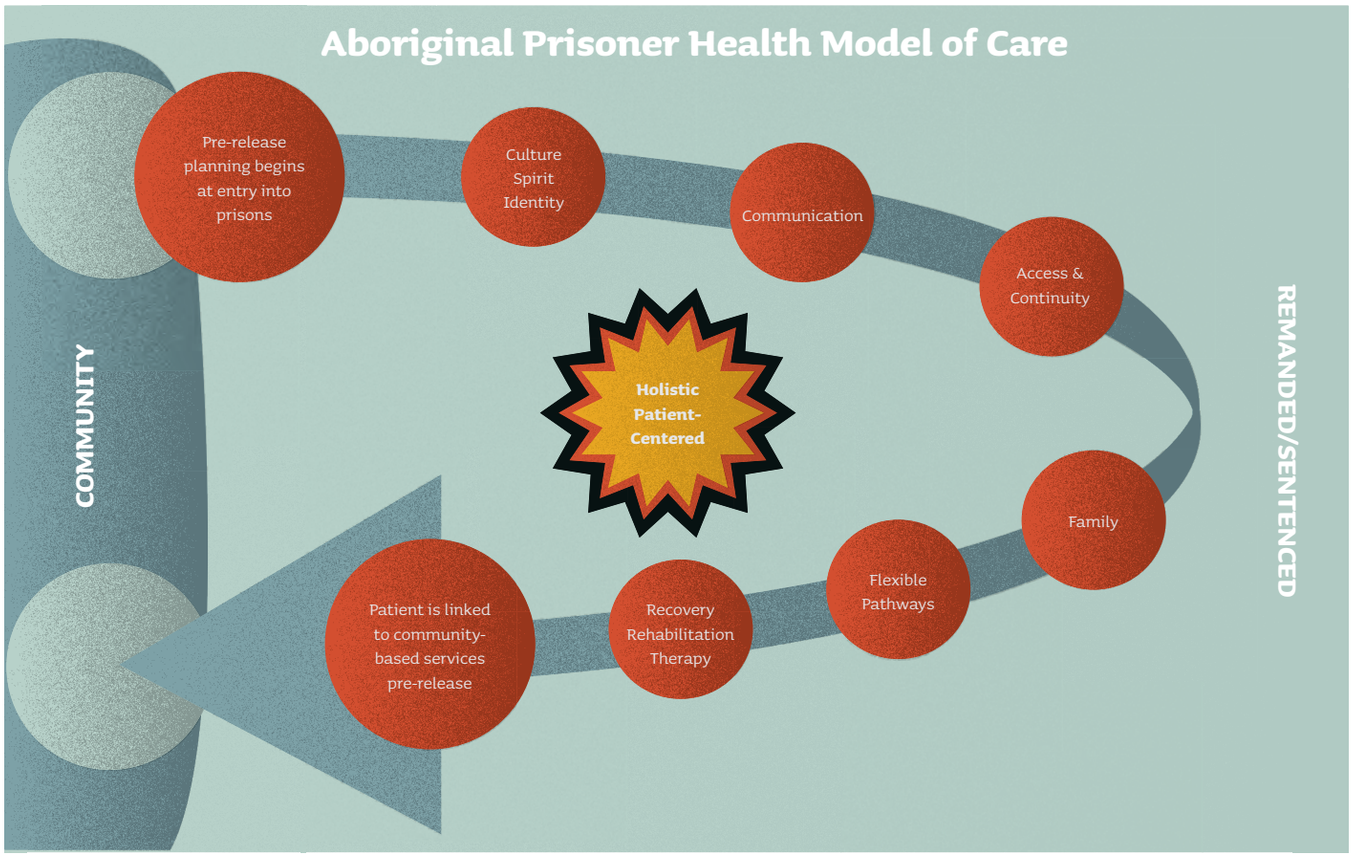

Figure 5 Aboriginal Prisoner Health Model of Care – draft for stakeholder workshop.

3. Approach (cont.)

1. ***Workshop Two: Core elements and key considerations*** **–** groups were asked to discuss the following:

a. Are all of the core elements supported by the key considerations listed below?

b. Are there further key considerations that would enhance the model?

2. ***Workshop Three: Facilitators, barriers and opportunities for implementation*** **–** individuals were asked to identify their comments or suggestions regarding:

a. Additional facilitators of implementation

b. Potential barriers to implementing the model

c. Opportunities for immediate implementation (within the next 6 months)

The prompt for the implementation workshop is shown in *Figure 6* below.

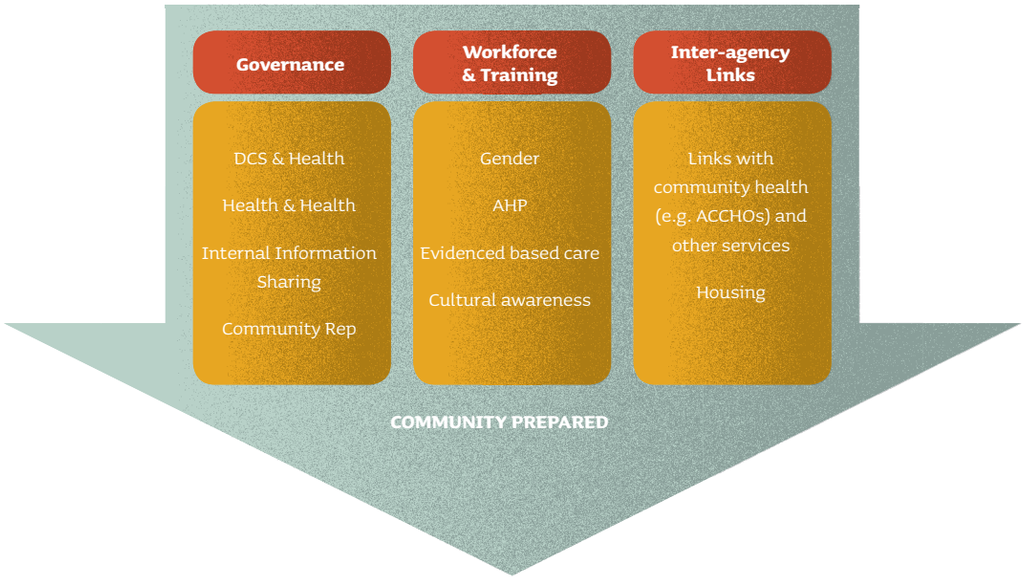

Figure 6 Facilitators of implementation – draft for stakeholder workshop

Group discussions were facilitated by Wardliparingga project staff, who also scribed the key findings from the discussions. This feedback was used to improve the draft and directly contributed to the finalised model of care.

4. Findings

This section describes the key findings from the review of literature, stakeholder consultation and stakeholder workshop.

4.1. Findings – Review of literature

The review of published and grey literature regarding models of care for Indigenous prisoner health began with a review of recent work undertaken by Wardliparingga that potentially could inform the development of a model of care. In particular, the Wellbeing Framework for supporting primary healthcare services to provide appropriate care for Aboriginal people with chronic disease (Davy et al. in press) was adapted for the South Australian Aboriginal Heart and Stroke Plan 2017-2021 (Wardliparingga 2016a). The adapted Wellbeing Framework (shown in *Figure 7* below, and shown in more detail in Appendix 3) illustrates the necessary components of culturally appropriate care. This model underpins all aspects of the Model of Care for Aboriginal Prisoner Health and Wellbeing for South Australia.

Figure 7 Culturally appropriate care (Source: SA Aboriginal Heart & Stroke Plan)

There is very little published literature regarding models of care for Indigenous prisoner health, within Australia or internationally. We found two Australian and one international program of interest.

Winnunga Holistic Health Care Prison Model

The only published model of care for Aboriginal prisoner health in Australia found was the Winnunga Holistic Health Care Prison Model (Winnunga Model), which was developed by Winnunga Nimmityjah Aboriginal Health Service in 2007 in anticipation of the opening of the Alexander Maconochie Centre in Australian Capital Territory (Poroch et al. 2007; Arabena 2007). The Winnunga Holistic Health Care Prison Model is an in-reach model designed to address the needs of prisoners and ex-prisoners and their families, and to manage the cycle of incarceration both within and outside of the prison setting. As such, the Winnunga Model incorporates the first contact with the justice system, then takes into consideration the holistic care necessary for remanded and sentenced prisoners and their families within prisons and on release (see *Figure 8*).

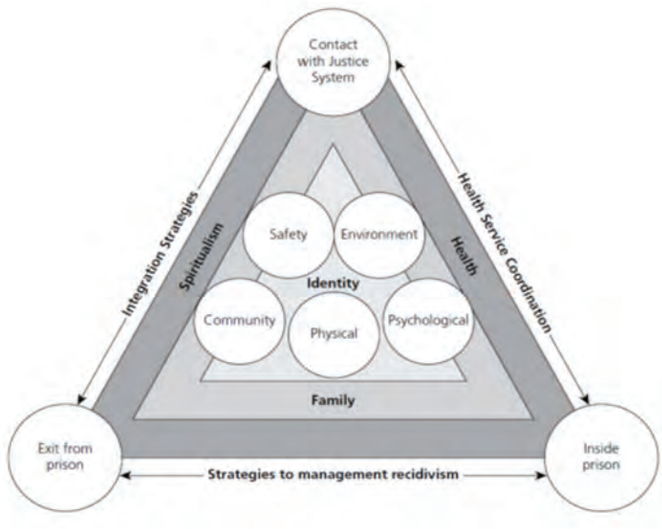

Figure 8 The Winnunga Holistic Health Care Prison Model (Source: Arabena 2007).

The key premise of the Winnunga Model is that post release needs should be addressed as a priority at reception into prison, and that the focus of imprisonment is preparing for release into the community. In turn, holistic care with prisoners and their families should prepare a person to be released into an environment which provides accommodation, employment, health services, and reintegration into the family and community. This premise directly influenced our model of care, as will become evident within Section 8.

Extensive consultation for the Winnunga Model with 22 ex-prisoners, 17 family members of ex-prisoners and 39 representatives of health, justice and community support organisations in ACT, identified three priority areas:

1. ***Post-release strategies.*** Release planning should begin at entry into prison, with the focus on preparing for release into the community environment with appropriate support, beginning as the prisoner steps out of the prison gate. Strategies such as accompanied transport and access to appropriate accommodation; assistance in meeting Centrelink commitments, job training and employment obligations; and assistance meeting parole commitments, keeping appointments including primary

4. Findings (cont.)

health, mental health or drug and alcohol withdrawal services. Effective post-release strategies require the development and maintenance of strong inter-organisational relationships with health, community and justice support organisations, as well as systematic release planning.

2. ***Prison harm reduction strategies.*** Responsive harm reduction, including implementing a needle and syringe program; training in safe tattooing and air brush tattoos; voluntary testing for Hepatitis B and C and Human Immunodeficiency Virus (HIV) at entry into and exit from prison. Appropriate counselling and support for positive results; and immunisation for blood borne and sexually transmitted infections.
3. ***Mental health strategies.*** Given that transgenerational trauma is experienced by many Aboriginal people, both within prisons and the community more broadly, attention to identifying Aboriginal prisoners' cultural, social, spiritual and mental health needs, and providing emotional and clinical therapeutic support for mental health within the prison setting is recommended. Examples include Elder support; Link-Up assistance; grief support and family death and burial assistance.

Relevance of the Winnunga Model

The Winnunga Model differs in scope from what Wardliparingga was contracted to develop, insofar as the Winnunga Model is an in-reach model from one Aboriginal Community Controlled Health Organisation (ACCHO) into one prison in ACT, while Wardliparingga was asked to develop a state-wide model of care for SA Prison Health Service, which provides an in-prison primary healthcare service to eight of the nine prisons in SA. An in-reach approach, such as the Winnunga Model, would not be financially viable in South Australia (State funding for prisons; Commonwealth funding for ACCHOs and for Medicare). As a community health service, Winnunga Nimmityjah also provides care and support to patients who have been released from prison and services to prisoners' family members. It also plays a community-wide role in trying to manage or reduce recidivism. This broader role is not possible for SAPHS. Nevertheless, there were many ways in which the Winnunga Model has informed the South Australian model.

Culturally appropriate care for Aboriginal prisoners in Victoria

The Victorian Aboriginal Community Controlled Health Organisation produced a report exploring prison health services in Victoria to improve quality culturally appropriate care for Aboriginal people inside and outside of Victorian prisons (Halacas and Adams 2015). It made recommendations regarding the cultural safety of prison health services, improving partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) and improving prison health policy. Specific recommendations include:

- Increase involvement of ***Aboriginal Health Workers (or Practitioners) during prisoner reception*** in order to improve cultural safety, decrease service barriers and increase health service utilisation.
- Establish processes to increase access and utilisation of Aboriginal prisoners' ***pre-prison health and mental health histories*** as soon as possible to reduce the retelling of personal histories and improve continuity of care.
- Include ***mandatory mental health and substance use-related prompts within chronic disease management plans and reviews,*** and provide a greater focus on referral to prison alcohol and other drug services to increase diagnosis and treatment and address the very high rates of these illnesses among Aboriginal prisoners.
- Improve ***planning and transition support*** for prisoners released via parole and court as part of efforts to reduce recidivism, increase safety and reduce harm.
- Develop a transition health model for Aboriginal prisoners to improve continuity of care, health service engagement and reduce hospitalisation among recently released Aboriginal prisoners.
- Develop a ***pre-release checklist specifically for Aboriginal prisoners,*** including a process that ensures Aboriginal prisoners that have a health need or have refused treatment in prison are provided with additional post-release support to improve transition outcomes.
- ***Prison health services should develop relationships with ACCHOs*** and explore the feasibility of a prison health-ACCHO network in order to develop cultural safety and improve transition outcomes.

Relevance of the Victorian Report

The Victorian Report had strong utility and relevance for the development of the South Australian Model. The recommendations were highly appropriate and were able to be applied directly in the development of the South Australian model.

New Zealand prison model of care for serious mental illness

The Northern-Midland Region Prison Model of Care for Serious Mental Illness (PMOC 2011), was developed to improve the consistency and quality of prison mental health in-reach care in the northern part of New Zealand. This project provides an example of a targeted model with minimum standards and timeframes for care delivery that has been shown to increase screening, referral, treatment and engagement of prisoners in appropriate mental health care services (Pillai et al 2016). Importantly, the model was able to demonstrate improvements without extra resources. This was achieved by clarifying professional roles and tasks and consistently applying processes. The implementation of the model was fully supported by the health and correctional services involved and the efficiency gains were a result primarily of reallocation of tasks. For example:

"Mental health nurses were significantly more involved in triage assessments in the prisons after the introduction of the model, freeing medical officers and other team members to be more involved in other

aspects of service delivery such as treatment and release planning." *(PMOC 2011: 6)*

Key features of the New Zealand model include:

- ***Screening*** for serious mental illness on reception into prison, with an initial health assessment completed by the prison health team within 24 hours to 7 days depending on the clinical indicators and advice of the triage team
- ***Referral*** pathways involving dual referral to the triage team and prison health service to ensure the referral is received and an appropriate response is initiated; referral pathway has clear and detailed process and minimum standards for response time
- ***Assessment*** in a staged approach ranging from brief to comprehensive mental health assessments with review by the multidisciplinary team (e.g. psychiatrists, mental health nurses, social workers, clinical psychologists, alcohol and other drug clinicians, occupational therapists and cultural workers) for all new assessments; documentation is clearly prescribed, including communication to prison health and community health services (where relevant) and inclusion within the prisoner's electronic clinical file
- ***Treatment*** to reduce or eliminate symptoms of mental illness; improve functioning of prisoners with serious mental illness to enable them to participate and benefit from the rehabilitative opportunities within the prison environment; assist prisoners with serious mental illness to recognise early warning signs of relapse and help them (and prison staff) to know what to do, who to contact and why this response is necessary; have a key role in release planning and ensure that appropriate clinical psychosocial, cultural, social and support services are in place prior to release to reduce the risk of relapse, improve the chance of sentence compliance and successful community reintegration
- ***Release planning*** as part of the collaborative interagency relationship that includes all procedures related to the time of release from prison or transfer to another prison that are needed to facilitate continuity of care for people who need to be engaged with general mental health services or other health or social care agencies upon release

Relevance of the New Zealand Model of Care for Serious Mental Illness

Although not specifically addressing the needs of Indigenous prisoner health in the broader sense, there was much in the New Zealand Model that could be of use for the development of the SA Model. Of note is the fact that health and corrections agencies worked together to ensure that the model was implemented effectively: "Critical to the success of the Prison Model of Care is regular (fortnightly) collaborative and cooperative interagency liaison meetings for shared treatment planning and review" (PMOC 2011: 20). This approach is recommended for the implementation of the South Australian model.

4.2. Findings – Consultation

The findings of the consultations are presented in three sections, which highlight the differing voices and perspectives of: (1) Aboriginal community Elders; (2) Aboriginal prisoners as 'consumers' of SAPHS services; and (3) staff and management within SAPHS and DCS within the prisons.

Aboriginal Elders' perspectives

There were several key themes that emerged through consultations with Aboriginal Elders as part of this project. In particular, community Elders strongly asserted the importance of preventing youth from becoming incarcerated within adult prisons by addressing the needs of vulnerable adolescents and young people who have contact with child protection and correctional services.

Community Elders also spoke of the need for more Aboriginal staff within the courts, prisons and correctional services interfaces more broadly, particularly Aboriginal psychologists to be involved in pre-sentencing and pre-release assessments and planning.

The prison setting was also viewed as proving an opportunity for health promotion to increase basic health literacy.

There was some confusion regarding the relationship between James Nash House (JNH), the forensic psychology unit, and prisons, particularly in terms of transfers into and out of JNH and levels of sedation that have impacts on prisoners' understandings of court proceedings.

Strong requests for therapeutic mental health services (not just mental health assessments) and screening for sexually transmitted infections and blood borne viruses came from community Elders.

Concerns about timely access to care included the suggestion that follow-up assessments in relation to psychological conditions would benefit from waiting until a person has fully withdrawn from alcohol or other drugs, as symptoms can be confusing and untimely assessments can be inaccurate, yet remain in place inappropriately for long periods of time.

Information and communication systems within and between prisons could be improved, including that requests for healthcare are noted within medical notes.

Community Elders noted the need to keep non-Indigenous staff accountable to providing culturally appropriate care to Aboriginal prisoners at all stages of the prison journey. Many of these matters were raised in the context of experiences of institutional racism, not just within prison settings but also within the police, courts and sentencing situations that result in Aboriginal incarceration. Community Elders noted that negative assumptions regarding Aboriginal people can determine what type of care is offered or provided to Aboriginal patients, both within prisons and in community healthcare settings.

4. Findings (cont.)

Community Elders advocated for holistic approaches to the needs of prisoners, including housing and family support, as well as family violence and substance misuse treatments to break the cycle of re-incarceration. The Grannies Group in particular asked how change would be monitored within the new model, and strongly urged that no change is better than giving prisoners and their family members false hope.

Aboriginal prisoners' perspectives

Whilst out of scope for Wardliparingga,[3] the project incorporated SAPHS consumer engagement consultations to inform the model of care. This engagement with prisoners was conducted as part of SAPHS responsibilities under the National Safety and Quality Health Service (NSQHS) Standard Two - Partnering with Consumers - and was undertaken by the SAPHS Project Officer and the SAPHS Manager of Consumer Engagement. While both female and male consumers were engaged, findings are not differentiated by gender.

One of the key findings of the consumer engagement was that prisoners would like more explicit communication from prison health staff regarding their care, including reasons why particular types of care (e.g. medications) were refused. Opportunities for health promotion and education to increase health literacy were requested by prisoners. Similarly, the prisoners we spoke with requested wellbeing support, including nutritional dietary plans – for diabetic diets – and formal exercise programs to combat excessive weight gain, as well as meaningful structured activities to manage excessive rumination, that is, engaging in prolonged negative thinking.

The issue of institutional and interpersonal racism came to the fore within the consumer engagement consultations. For example, Aboriginal prisoners relayed experiences of racism while incarcerated. Requests to be treated as a person with respect and dignity, rather than as a number or a stereotype or a criminal, were strongly expressed. Some of the Aboriginal prisoners we spoke with perceived that inaccurate assumptions regarding excessive alcohol use by 'all' Aboriginal people seemed to influence the way they individually were treated in prison.

Concerns were also raised for incarcerated people who come from communities where Aboriginal languages are the primary means of communication, where traditional cultural Law is still being practiced, and that are often located in remote parts of South Australia or other States and Territories. In particular, there was a perception that remote peoples are over-represented in South Australian prisons. There were also concerns about the ability of those Aboriginal peoples with English as a second, third or fourth language to understand fully the details of operations within health and correctional services settings.

Better interpreter services and thorough cultural awareness training for all staff were requested by the prisoners we spoke with. Cultural awareness training needs to include information on the history of different Aboriginal peoples and communities within South Australia and more broadly, how to work with Aboriginal people, and how protocols differ for different groups. The prisoners we spoke with also requested more Aboriginal staff within prisons to assist with cultural appropriateness of care and general treatment.

Some of the prisoners we spoke with detailed examples of reporting health concerns to health staff, but receiving no follow-up assessments or care. Others noted examples of being administered the wrong medications. Dental care was a key issue in some prisons but not others. In particular, non-metropolitan prison settings were at times unable to engage local dentists, which results in long, uncomfortable and detrimental physical journeys for patients to receive dental care in Adelaide.

An example of a specific patient's journey for cardiac care is provided below (with explicit permission by this patient).

This particular patient is an Aboriginal Elder who was required to attend the Royal Adelaide hospital to receive cardiac care. At this time, the patient was residing at Port Lincoln Prison. The patient's family was informed that the patient would be travelling to Adelaide to receive cardiac care and would be travelling with a nurse in attendance, however the patient was transported to Adelaide alone. On route to Adelaide, the patient was transported to Port Augusta Prison (approximately 3.5 hours) shackled in a van. The patient stayed overnight at Port Augusta Prison, then was transported to Yatala Labour Prison (approximately another 3.5 hours), again shackled in a van. The patient then resided at Yatala Labour Prison and, in the coming days, attended the Royal Adelaide Hospital. After arriving at the hospital, the patient was taken to the wrong clinic and as a result missed her/his appointment with the specialist. The patient was then returned to Yatala Labour Prison without receiving the required care. The patient believed that a maximum stay of two weeks was all that was permitted at Yatala Labour Prison, after which time s/he would be returned to Port Lincoln Prison, regardless of whether the appointment with the specialist had occurred. However, in this specific scenario, the patient relayed that s/he was able to stay at Yatala Labour Prison for four weeks to attend a follow up appointment before being transported back to Port Lincoln Prison.

The patient further described how, when anyone is transported to Yatala Labour Prison, they lose their bed, cell and cell mate, employment and privileges. On return to Port Lincoln Prison, the patient stated that you need to "start again" to earn privileges, await allocation of a bed and new cell mate and await new employment opportunities. The patient also commented that the thought of having to go through this process on return had a huge impact on patients' stress and anxiety levels. As a result, many patients are reluctant or decline to attend necessary health appointments or to access health care in order to preserve their current living conditions within the prison system. This situation creates obvious barriers to accessing necessary healthcare.

[3] The original scope was designed as a desktop evidence review with limited consultation with key stakeholders. In order to speak to prisoners, approval from a registered Ethics Committee would have been required for a third party such as SAHMRI to engage directly with prisoners. As the engagement was done via quality improvement processes by SAPHS staff, no such approvals were required.

A diagram illustrating this patient's journey is provided in *Figure 9*.

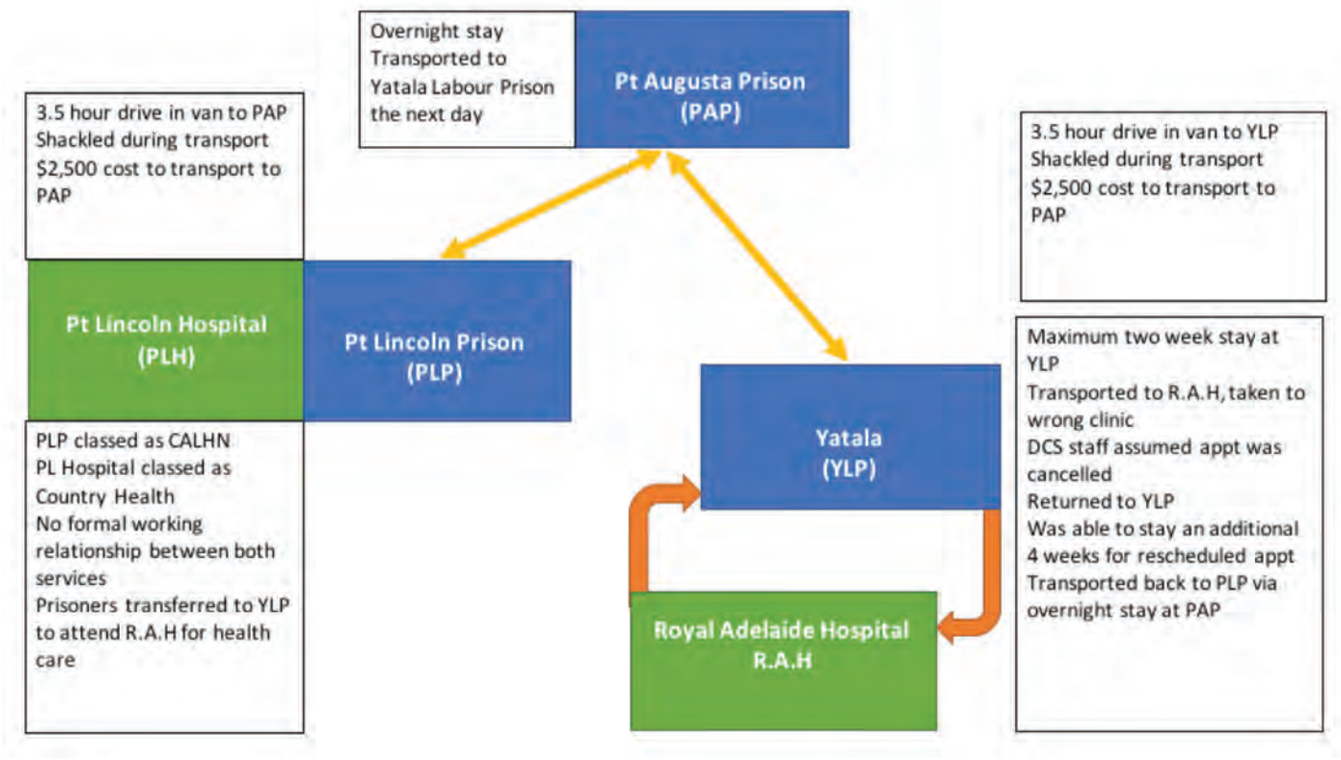

Figure 9 Patient journey map – Port Lincoln to Royal Adelaide Hospital for cardiac specialist care

It was perceived by some SAPHS staff that this patient journey illustrated some of the inefficiencies within the existing DCS and SAPHS systems, which could be improved with better coordination of care between CALHN, who holds the budget for prisoner health, and Country Health SA, who holds the budget for country hospitals and health clinics. If accurate, this also illustrates the need for high-level governance agreements between CALHN, Country Health SA LHN and DCS, (see Recommendation 3). However, there may be other dynamics at play, including the range of service capabilities of regional hospitals. Patients are referred to the Royal Adelaide Hospital when specific tests or services are not available locally.

Health and correctional services staff and managers' perspectives

Discussions with Aboriginal and non-Indigenous staff and managers from both SAPHS and DCS took place at Port Augusta Prison, Adelaide Remand Centre, Port Lincoln Prison, Cadell Training Centre, Yatala Labour Prison, Mobilong Prison, Adelaide Women's Prison and Adelaide Pre-release Centre. Health and correctional services staff at Mount Gambier were not consulted as part of this project because Mount Gambier is privately managed and health services are not provided by SAPHS. Staff and mangers from Mount Gambier Prison were invited to the Stakeholder Workshop.

These discussions have given rise to key themes that informed many of the components of the draft model of care. This section of the consultation findings is organised by the components that can be found within the Detailed Framework for the model.

Priority conditions – Gender-specific needs

Staff and managers at most prison sites discussed priority health conditions in terms of the gender specific needs of Aboriginal people, with recognition of the importance of male health staff attending to male patients' sexual and reproductive health and psychological or emotional wellbeing and female staff attending to female patients' reproductive and sexual health. In addition, staff and managers at the Adelaide Women's Prison and Port Augusta Prison (which also accommodates approximately 25 female inmates) spoke of the physical, emotional, psychological and social health matters that affect female prisoners in very different ways from male prisoners. These included: personality disorders and undiagnosed acquired brain injuries; the impacts of incarceration upon children and other dependents; impacts of being released off court without being able to attend to contraceptive needs; gynaecological, antenatal and maternal health issues, including the separation of babies and mothers soon after birth; the effects of poor diet, low levels of physical activity and excessive rumination upon weight, physical appearance and self-esteem; the impacts of releasing a person back to a household that expresses family or domestic violence; and implications of changing eligibility criteria for the National Disability Insurance Scheme (NDIS) on pre-release planning for community based care and support.

4. Findings (cont.)

Priority Conditions – Chronic conditions

Staff and managers at almost all prison sites noted the importance of chronic conditions, with diabetes being noted most frequently and in a range of ways. For example, in prisons where self-management is possible and encouraged, some patients experienced such dramatic improvements in their feelings of wellness that it inspired them to seek further information and understanding, as well as assessment and management of their general health. In contrast, and not surprisingly, within prison settings where insulin treatments are inhibited by lock-down, thereby creating enormous challenges for managing diet and medication and resultant feelings of illness, staff noted that patients' compliance with self-managing treatment regimes was very unlikely upon release. Difficulties in offering or providing appropriate diabetic diets, particularly in sites with long lock-down periods, also heightened challenges in managing diabetes.

Other chronic conditions mentioned included asthma, cardiovascular diseases, kidney disease, and cancer. In addition, prison staff noted that many of the recidivist prisoners experienced homelessness, compounded by long-term issues with mental illnesses and substance misuse disorders that give rise to additional challenges in managing their other chronic conditions.

Priority Conditions – Mental illness

Staff and managers at all prison sites noted the high prevalence of 'mental health' issues, but the ways these were described seemed to indicate that staff were generally referring to behavioural risks of patients harming themselves or others, as well as substance related symptoms rather than psychiatric conditions, grief and loss management or other psychological or emotional imbalances. When prompted, staff recognised a need for therapeutic mental health services to support not just criminogenic factors (e.g. violence, substance misuse) but also underlying emotional and psychological conditions. There was limited acknowledgement of mental illness as a chronic condition in itself, as well as a risk factor for other chronic conditions, and even an outcome of other health issues.

One prison site which described a nuanced approach to assessing mental health in relation to Aboriginal peoples was Port Augusta Prison, which recognises some psychiatric symptoms as potentially stemming from four sources: (1) spiritual illness; (2) substance withdrawal; (3) psychosis or other underlying psychiatric condition; or (4) metabolic imbalance (e.g. hypoglycaemia due to insulin). It is hoped that learnings such as these can be shared between prison sites in order to better inform assessment processes in a culturally relevant manner.

Priority Conditions – Communicable diseases

Not all prison sites' staff and managers discussed communicable diseases, but those who did mentioned the high prevalence of blood-borne viruses and sexually transmitted infections, and stressed the importance of early screening, vaccination and regular treatment. Needle and syringe exchange programs, which have demonstrated effectiveness in preventing transmission of communicable diseases, were not mentioned, nor were point of care testing opportunities, which is described within the findings of the literature review in Section 4.1.

Priority Conditions – Substance misuse disorders

Staff and managers within almost all prison sites described high levels of substance misuse disorders amongst Aboriginal prisoners within their care, which contradicts the published evidence (see Section 7.1). It is possible that staff are expressing unconscious bias in terms of prevalent media representations of Aboriginal alcohol or other drug use, and as noted above, may also be misdiagnosing symptoms that may in fact be attributes of other underlying causal factors.

That said, there are high rates of alcohol and other drug use disorders within the prison population as a whole, yet those prisoners on remand or short-sentences (which often characterise the Aboriginal prisoner population) are not eligible for substance misuse programs. Concerns were raised that drug and alcohol detoxification and withdrawal supports may not be adequate to meet the needs of Aboriginal patients. Finally, some sites openly noted that some prisoners have developed substance misuse disorders as a result of being within prison, having arrived with no previous history of drug use.

Priority Conditions – Disability

Staff and managers within only one prison site openly discussed disability, citing the probability of high rates of undiagnosed acquired brain injuries, particularly within the female prison population. Acquired brain injuries can result from physical violence, substance misuse or other forms of physical trauma such as motor vehicle accidents. Undiagnosed foetal alcohol spectrum disorder (FASD) may also be a factor.

Core Element – Pre-release planning from entry into prison

Staff and managers at all prison sites discussed pre-release planning, with a particular emphasis on the frustrations of patients being released 'off-court' where their medical notes and pre-release planning details remain at the prison. Several examples were relayed, including one prisoner being released to a regional bus stop at 5:30pm on a Friday, with an expired bank card and no ability to contact family members to let them know s/he had been released nor to request accommodation for the night. When 'notice of court' is affecting up to 20 people per day, health staff believed it would require a fulltime position to prepare appropriate medical records and scripts for all of them 'just in case'.

Many staff and managers expressed awareness and concern about the lack of throughcare (i.e. continuity of care into the community upon release), noting that prisoners are being released to return to violent relationships, social groups who use substances at high levels or to unstable housing arrangements. Staff at one prison described ideal discharge planning as including the following: full medication for one week; all relevant repeat medication scripts

(e.g. contraception); pre-booked GP appointment in community of residence; valid/renewed Medicare card and Healthcare Card and knowledge of entitlements to free prescriptions (CtG scripts); referral to appropriate drug and alcohol services if required; in-hand summary of individual's medical records, including medication history and results of any blood tests; valid credit/debit cards, drivers licence, information pertaining to relevant service locations, hours and services provided (e.g. community health clinic, Centrelink, banks, housing or accommodation services) in their community of residence.

People with complex health and social needs may require a multidisciplinary approach to pre-release planning, involving a social worker, case management coordinator, healthcare team and community corrections officer. It was suggested that pre-release planning should begin upon a person's arrival into the prison and should continue in a consistent and cumulative manner as that person transitioned to other prisons as well.

When prompted, staff and managers at several prisons observed that lower numbers of Aboriginal people progress to low-security prison sites (i.e. Cadell Training Centre, Adelaide Pre-release Centre), which in large part they believed was to be attributed to security ratings, and in lesser part to prisoners' social connections. For example, a woman may choose to stay in the higher security section of the women's prison because of the lower numbers of Aboriginal women in the pre-release prison and feelings of cultural or social safety; a man may choose to be transferred from Mobilong Prison back to Yatala Labour Prison so he can still receive visits from family members who are unable to travel to Murray Bridge.

Core Element – Culture, spirit, identity

Staff and managers within several prison sites were aware of the cultural, language and sometimes spiritual needs of Aboriginal prisoners, but expressed this almost exclusively in relation to Traditional Aboriginal peoples from Central Desert and further north. Most sites saw the needs of 'urban' Aboriginal people as more or less identical to those of non-Indigenous prisoners. That said, staff and managers at many prison sites recognised the value of appropriate Ngangkari and other Traditional Healers for Aboriginal people, noted the importance of kinship care (e.g.co-locating family members for support), and believed there is further scope for more extensive peer support amongst Aboriginal prisoners. There was some awareness of the prevalence of grief and loss and the importance of family members attending funerals within the community as possible, but very little discussion of the profound intergenerational trauma that characterises the Aboriginal prisoner population generally.

Core Element – Communication

Staff and managers at many of the prison sites discussed communication issues in a range of ways, including the need for interpreter services, literacy-appropriate resources and procedures for patients. Several sites expressed awareness and concern that they may not be best meeting the needs of Traditional Aboriginal people, particularly those of males where the health teams are predominantly or exclusively female. Staff and managers also spoke of the need to clarify and strengthen communication processes between DCS and SAPHS to better support patients' health and wellbeing needs, frequently recognising that correctional and health services staff share care for prisoners. Furthermore, the need for better communication between prison sites was also raised as a significant issue.

Core Element – Access and continuity

Staff and managers at all prison sites expressed concern regarding Aboriginal patients' access to healthcare services and many described concerns regarding continuity of care both within and between prisons, as well as between community and prison settings. For example, prison health teams often have difficulty accessing patients' community health records in a timely manner after arrival. This can be at the community services end or, at times, as a consequence of communication breakdowns within prison sites, resulting in access to medical records taking one week or more rather than one day. Medications can be inconsistent with community-based medication due to prisoners' ineligibility for PBS, which is Commonwealth funded, while prisons are State funded. Similarly, maintaining medication compliance upon the release is challenging for some recently released people because of difficulties in accessing community health services for follow-up care post-discharge.

Continuity of care and managing medical records varies by prison, with some transitions working smoothly and others less so. Continuity of care and quality follow-up care is vital for Aboriginal people with chronic conditions. Prison health services may only see Aboriginal patients when they attend annual health checks as some Aboriginal people are choosing not to access healthcare services. This was often related to the gender profile of health teams, although one site in particular requested thorough cultural awareness training to better understand the needs of Aboriginal patients and how best to treat and work with Aboriginal people.

Core Element – Family

Staff and managers at most prison sites recognised – at least when prompted – the importance of 'kinship care', especially the co-locating of Aboriginal family members within a given prison, but did not generally go into much additional depth regarding the importance of family to prisoners' health. Exceptions included awareness of the importance of funerals, and the impact of being housed in a prison that is located too far away for family members to visit. Staff at the Adelaide Women's Prison spoke strongly regarding

4. Findings (cont.)

the need for the prison to be redesigned to accommodate babies and children, noting that South Australia has the only women's prison environments that provide no housing of children and babies.

Core Element – Flexible pathways

While this element builds primarily upon the patient journey mapping described above, it also draws on the consultations with staff and managers, and includes: telehealth and videoconferencing, specialist in-reach opportunities, in-reach by local health and social services, utilisation of existing specialist prison care (e.g. Aged and Infirm Unit at Port Augusta), and education and training opportunities to prevent re-incarceration.

Core Element – Recovery, rehabilitation, therapeutic services

Staff and managers at all prison sites described high levels of mental ill-health, and noted that psychiatric services are focused almost exclusively on sentence related assessments, rather than on therapeutic mental health care. In some prison sites, DCS social work staff provide brief interventions, such as cognitive behavioural therapy-informed group and individual activities. Some staff and managers expressed a need for cultural competence training and recognised the value of increasing Aboriginal health staff as well as Aboriginal psychologists and social workers to support assessment and provide better treatment for spiritual, emotional, psychological, cultural and social health. When prompted they agreed that Aboriginal or culturally competent professionals would be better able to interpret behavioural and contextual circumstances in a culturally informed manner.

Eligibility for criminogenic programs and other interventions are often restricted to prisoners who are serving longer sentences, rather than to remanded prisoners or people on shorter term sentences, which characterises many within the Aboriginal prisoner population. This means that many Aboriginal people are systematically excluded from interventions that have the potential to improve mental health as well as prevent re-incarceration.

Core Element – Patient linked to community services prior to release

Staff and managers at all prison sites expressed the importance of linking prisoners into community based services prior to release. Staff at one prison expressly requested that key contacts within community health clinics (e.g. Watto Purrunna, Nunkuwarrin Yunti) act as a liaison point for prison staff who wish to support Aboriginal patients' care back into the community, as well as to support the accessing of medical records upon a person's arrival at prison.

There was high awareness of the impacts of unstable accommodation upon release, and a recognition that many people with high rates of recidivism are responding to the pressures of unstable accommodation or homelessness. For example, staff noticed increases in the prison population that correspond to cold weather. On a related note, providing adequate transport to release people safely back to their communities was also described. For example, some prisoners who come from remote areas of South Australia, or even from across the border in Western Australia or Northern Territory, have enormous distances to travel to return to their home communities, yet their family members may not have the resources to drive 1200km round trip to collect a person for example, from the Indulkana turnoff near Marla, which is in turn is 1100km from Adelaide.

4.3. Findings – Stakeholder Workshop

The findings of the stakeholder workshop directly informed the final overarching design and detailed framework for the model of care. The workshop also provided a forum for Department for Correctional Services and SA Prison Health Services staff to meet and discuss shared concerns for the first time, as well as engage with other stakeholders such as union representatives and the non-government sector in a setting that supports solutions thinking.

Workshop One – Validating the model and revising the overarching design

Several key changes to the overarching design resulted from discussions during workshop one. These included the following:

- Formatting to remove implication of sequential pathway, instead components of holistic care
- Including priority health conditions being treated through the continuum of care
- Making gender-specific needs overt
- Linking 'pre-release planning' element to 'links to community-based services' element visually
- Adding the 'culturally appropriate care' model behind 'holistic patient-centred care', as represented by the purple circle that represents Figure 8 on page 20.

These changes have changed the draft overarching design as shown in *Figure 10 (below)* and *Figure 11* (page 29).

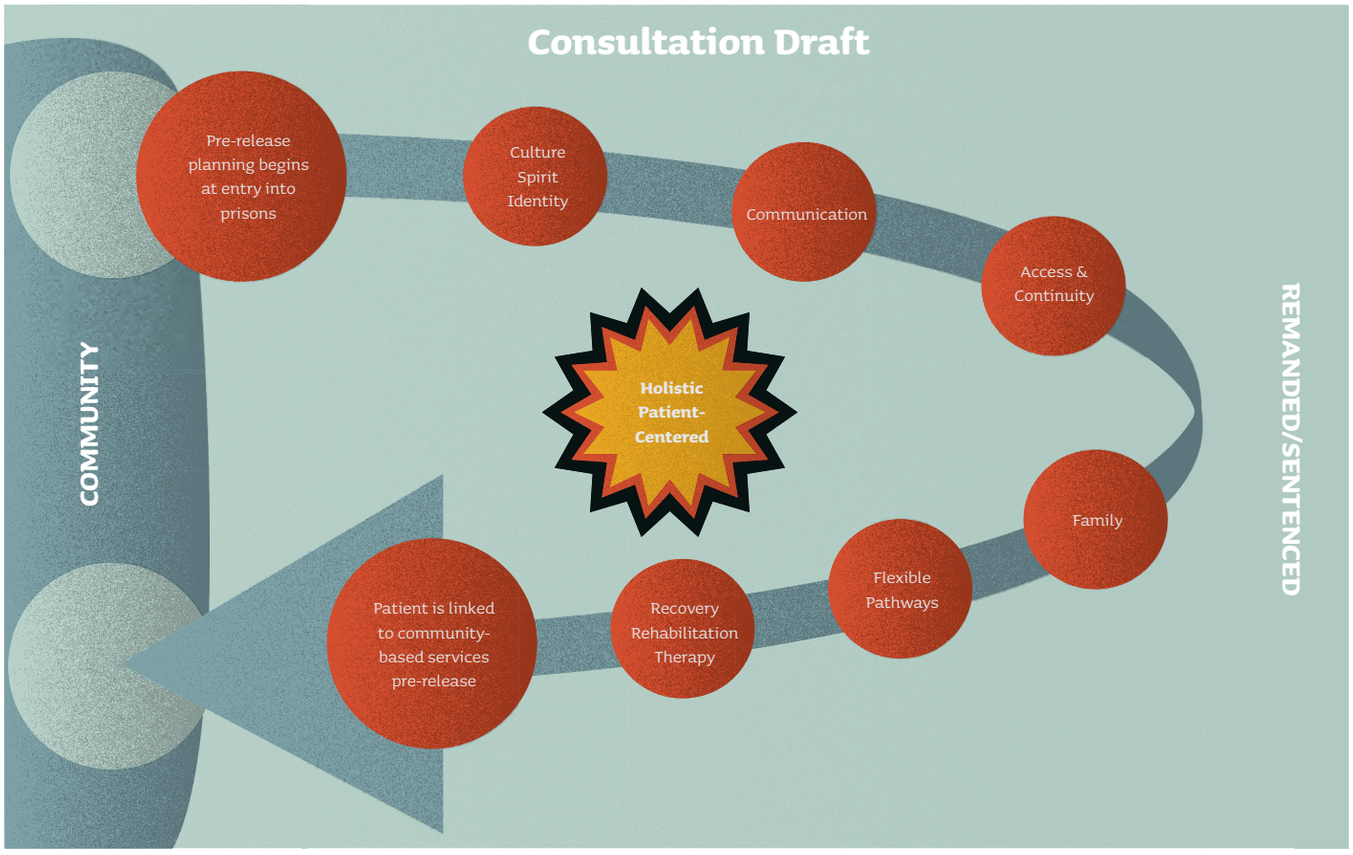

Figure 10 Consultation draft

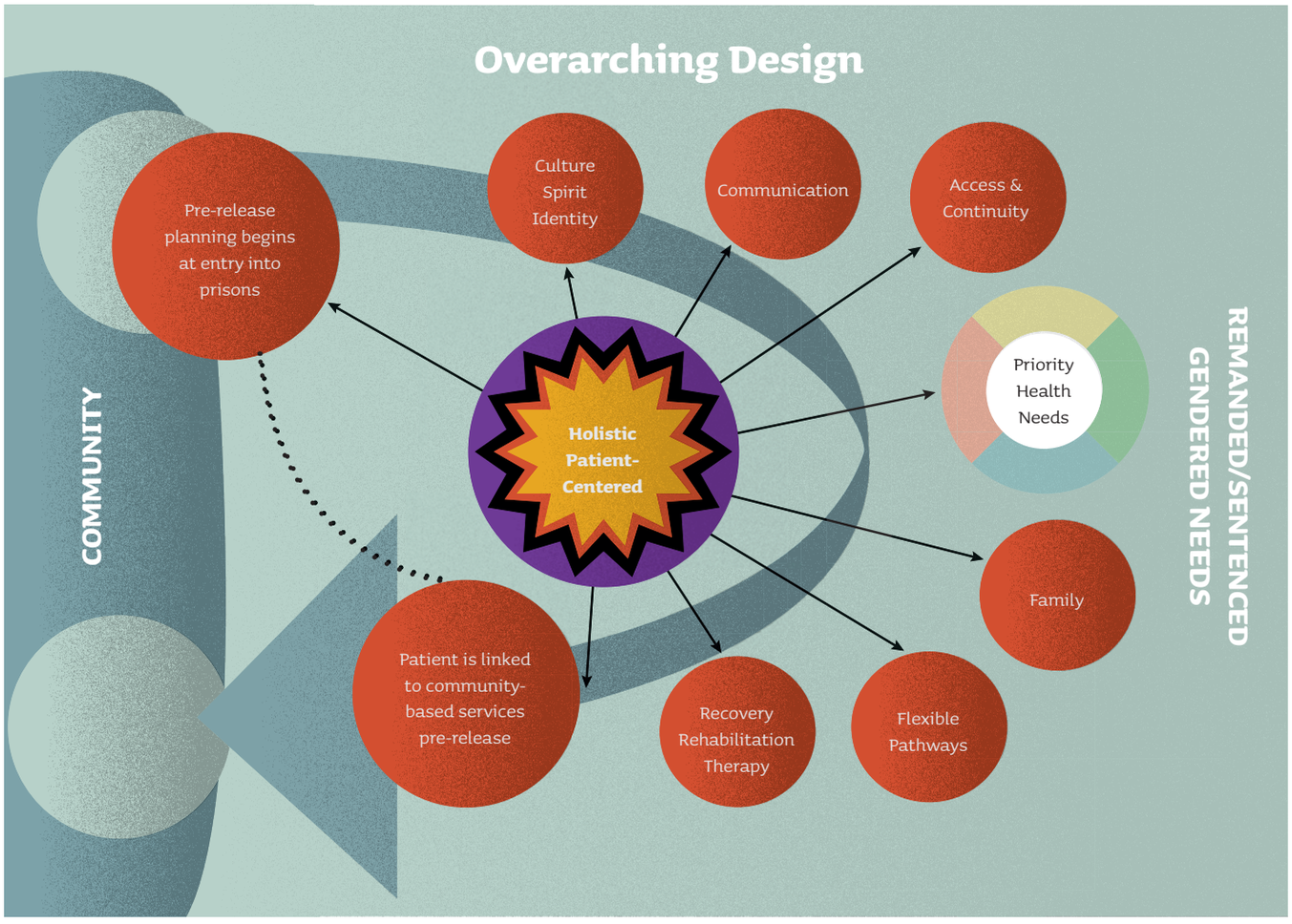

Figure 11 Final overarching design

Workshop Two – Core elements and key considerations

Each of the core elements is supported by a number of key considerations that resulted from either the evidence review, consultations or both. These key considerations were then transformed into recommendations as a result of the findings of the stakeholder workshop. In addition to the final recommendations, there were key discussions during workshop two regarding the clearly defining and communicating the responsibilities and roles of key stakeholders including the local health networks, SAPHS and DCS.

Workshop Three – Facilitators of implementation

Workshop three asked participants to comment in writing about opportunities and concerns about implementation. Detailed findings are presented in Appendix 5 below, which shows facilitators and barriers of implementing the model, as well as aspects of the model which could be implemented immediately (i.e. within six months).

5. Model of Care for Aboriginal Prisoner Health & Wellbeing in South Australia

As described above, the Model of Care for Aboriginal Prisoner Health and Wellbeing has an overarching design, theoretical basis with principles, evidence base, standards, core elements, key recommendations. In addition, the model makes note of facilitators of implementation, and comments on community preparedness – that is, prisoners being prepared to re-enter the community, and the community being prepared to accept former prisoners. The structure of the model is illustrated in *Figure 12* below.

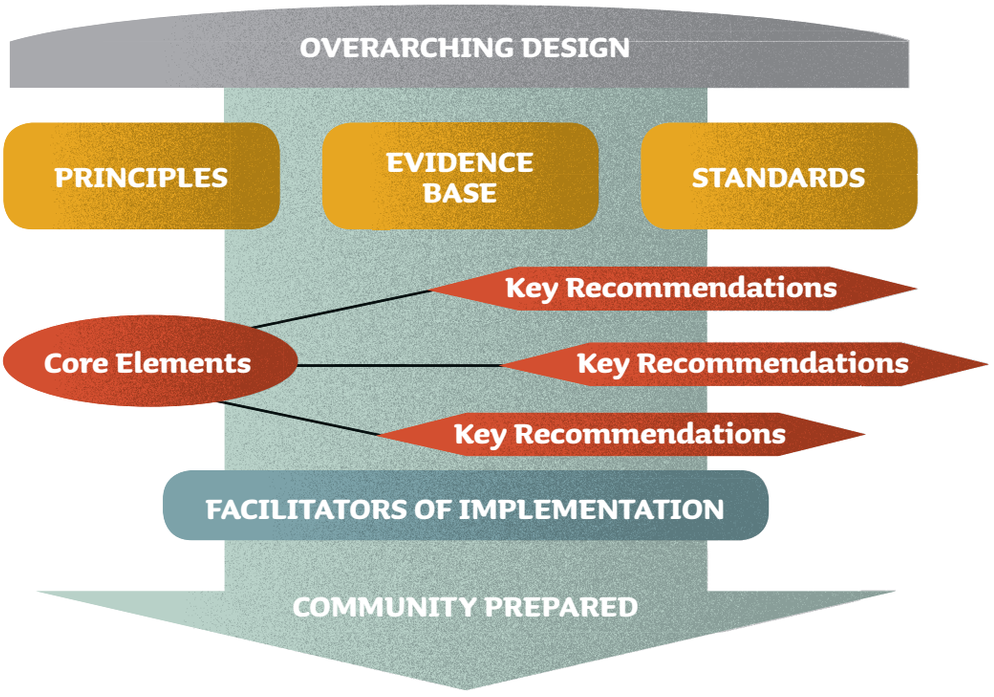

Figure 12 Structure of the model of care

5. Model of Care for Aboriginal Prisoner Health & Wellbeing in South Australia (cont.)

5.1. Overarching design

The Model of Care for Aboriginal Prisoner Health and Wellbeing is holistic, person-centred, and underpinned by the provision of culturally appropriate care. It recognises that Aboriginal prisoners are members of communities both inside and outside of prison, and that prisoners will be released to the community at the completion of their sentences. It notes the unique needs of remanded and sentenced prisoners, and differing needs by gender. The model has eight core elements: (1) pre-release planning begins at entry to prison; (2) culture, spirt and identity; (3) communication; (4) access and continuity; (5) family; (6) flexible pathways; (7) recovery, rehabilitation, therapy; and (8) patient is linked to community-based services pre-release. It also recognises the continuum of care in relation to priority health needs for Aboriginal prisoners. The overarching design for this model is presented in *Figure 13* below.

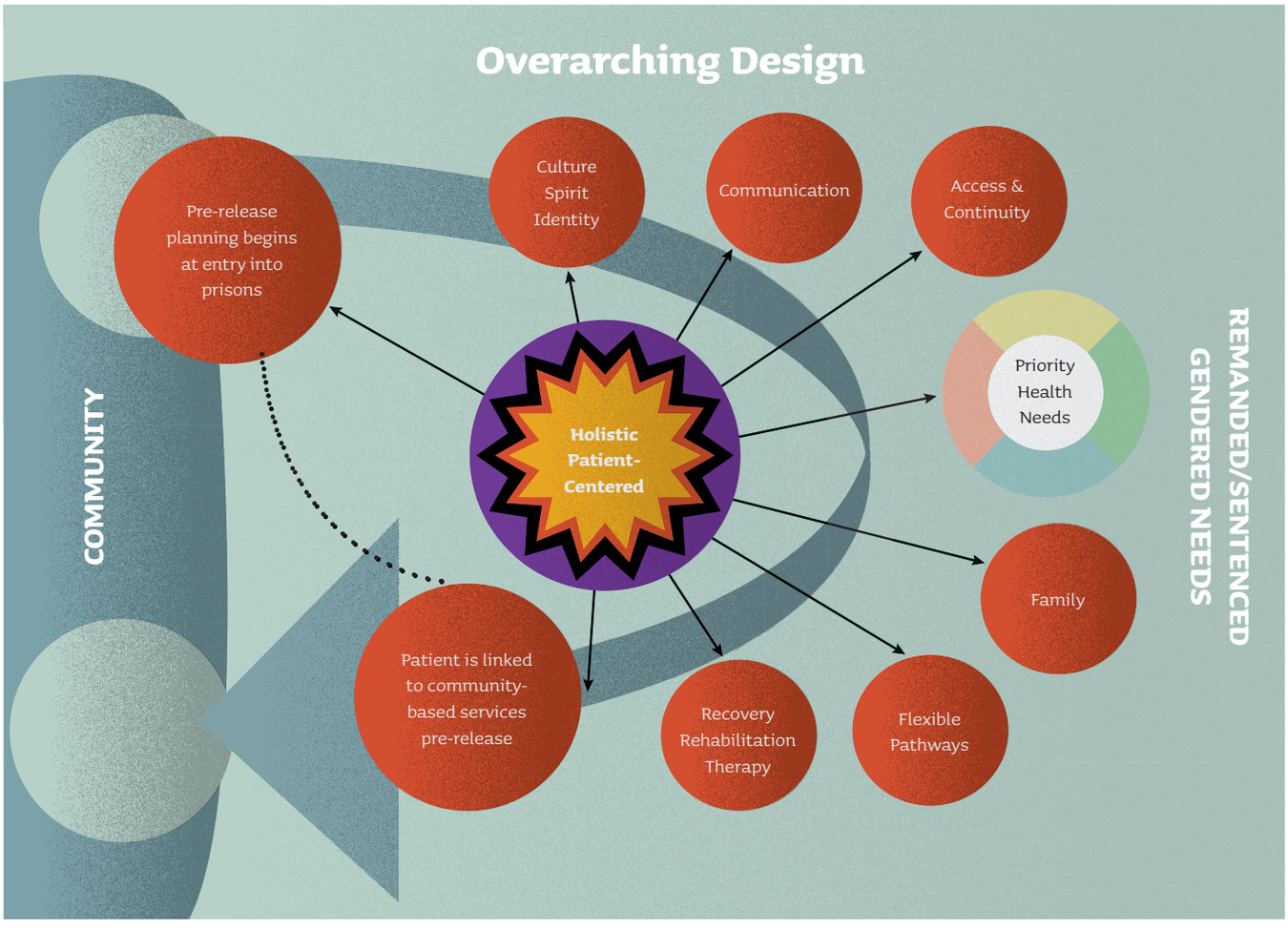

Figure 13 Overarching design: Model of Care for Aboriginal Prisoner Health and Wellbeing.

Although out of scope, the model recognises opportunities to prevent incarceration and opportunities to prevent recidivism within the community setting, as per *Figure 14* below.

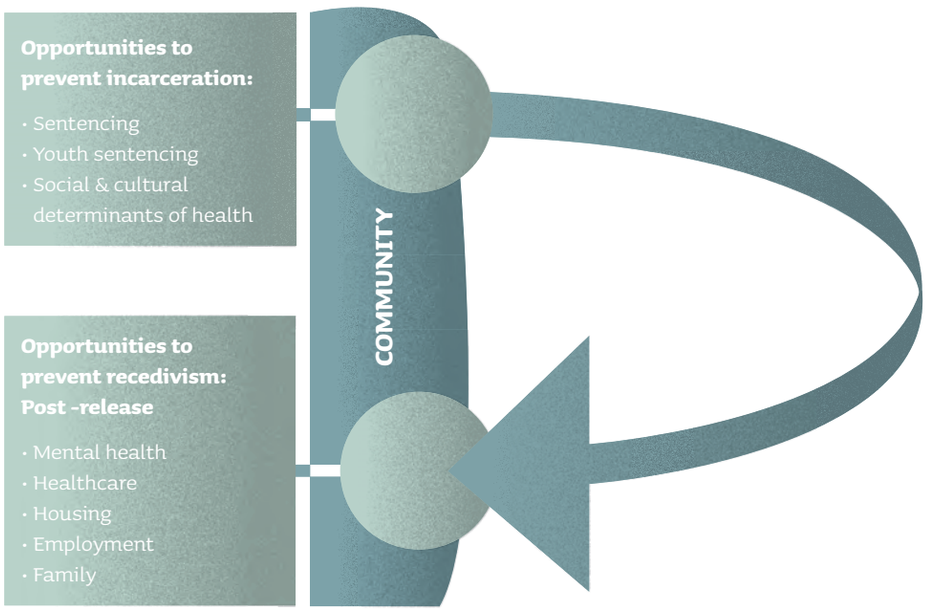

Figure 14 Opportunities to prevent incarceration and recidivism within the community.

The model is holistic and person-centred for a number of reasons, which are illustrated in Figure 15 below. The purple circle represents the provision of culturally appropriate health care services within a culturally safe service setting that is free from racism.

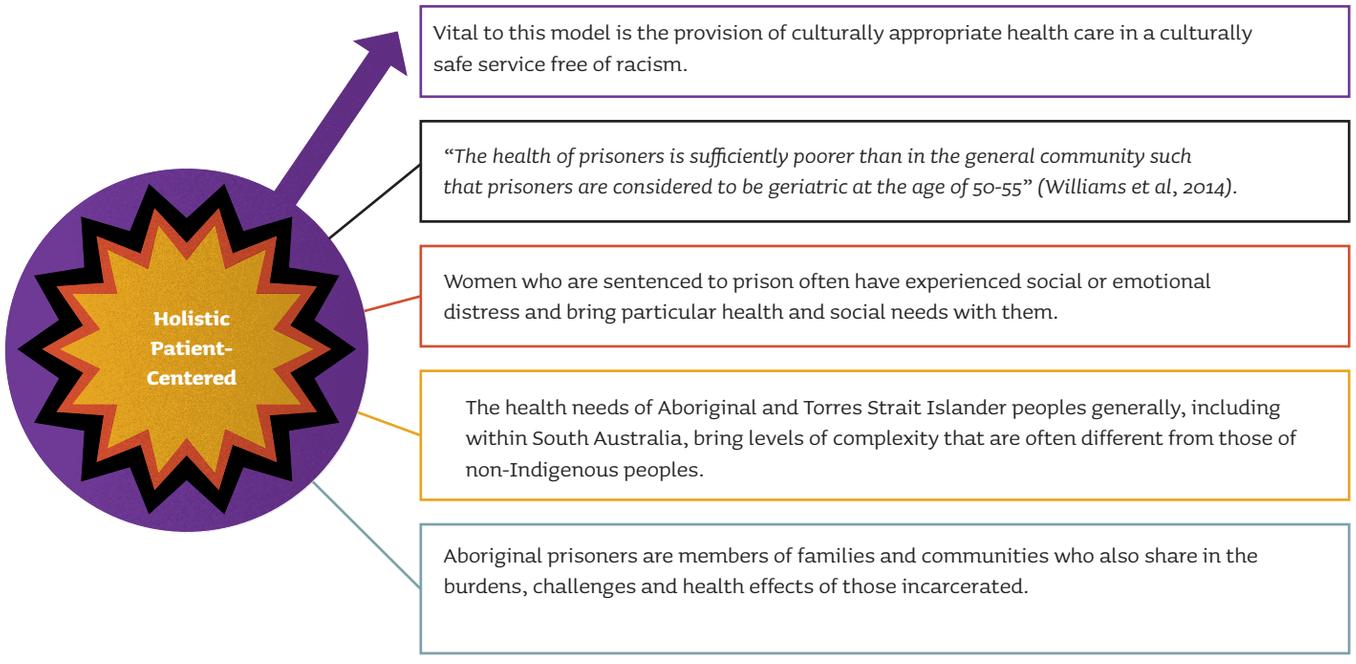

Figure 15 Holistic, person-centred care, underpinned by culturally appropriate service provision.

5. Model of Care for Aboriginal Prisoner Health & Wellbeing in South Australia (cont.)

5.2. Theoretical basis

The South Australian Aboriginal Prisoner Health Model of Care draws on the theoretical framework of the Winnunga Holistic Health Care Prison Model (Winnunga Model), which includes: human rights and treatment of prisoners, social and emotional wellbeing in prison and communication between support organisations (Poroch et al 2007). It also draws on the key principles of the Northern-Midland Region Prison Model of Care, which include: equivalency, people-centred, timely and effective access, compulsory mental health care, collaborative responsibility between health and corrections, multi-disciplinary approach, collaborative multi-agency approach, recovery paradigm, cultural partnership and responsiveness to family and community needs (PMOC 2011). The specific principles underpinning the South Australian Aboriginal Prisoner Health Model of Care are described below.

Principles

Human rights and treatment of prisoners

The United Nations Standard Minimum Rules for the Treatment of Prisoners (UN 1955) require respect for "the religious beliefs and moral precepts of the group to which a prisoner belongs"; that "rules will be applied impartially"; and that "there shall be no discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status". Regarding medical services in prisons, the Rules stipulate that:

"22. The services of a qualified dental officer shall be available to every prisoner.

"24. The medical officer shall see and examine every prisoner as soon as possible after his [sic] admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

"25. The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his (sic) attention is specially directed." (cited in Poroch 2007: 7-8)

Furthermore, the UN Committee on Economic Social and Cultural Rights provides for all people's enjoyment of "the highest attainable standard of health conducive to living a life in dignity" (UN 2000, para 1). In addition, the UN Human Rights Council adopted the Declaration on the Rights of Indigenous Peoples in 2006 (UN 2006), which included the following recommendations that are of relevance to Aboriginal prisoners:

"Article 24: Indigenous peoples have the right to their traditional medicines and to maintain their health practices including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

"Article 24(1): Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right." (cited in Poroch 2007: 8)

The preamble to the ACT Human Rights Act (ACTG 2004) may provide guidance regarding human rights approaches to Aboriginal prisoners:

"7. Although human rights belong to all individuals, they have special significance for Indigenous people – the first owners of this land, members of its most enduring cultures, and individuals for whom the issue of rights protection has great and continuing importance." (cited in Poroch 2007: 9)

Anti-racist prison cultures

A cross-sectional study of Aboriginal young people in Victoria showed that racism was significantly associated with poor overall mental health, poor general health, and marginally associated with increased depression (Stewart et al. 2011). With this in mind, countering racism can be considered a public health issue. For example, in a study from the United Kingdom found that "victims of discrimination were more likely to have respiratory illness, hypertension, a long term limiting illness, anxiety, depression, and psychosis" (Mckenzie 2003: 66). Racism can play out at individual and systemic levels and is notoriously challenging to identify and counter:

"One of the most persistent difficulties in operationalizing the health effects of racism is the complexity involved in attributing a particular event to racism. Racism can be subtle, unintentional, unwitting and, in the case of internalized racism, even unconscious." (Paradies and Williams 2008: 475)

Therefore, this model of care advocates the thorough and multi-levelled approach and application of a principle of non-racist prison cultures, which should include the provision of culturally appropriate care within culturally safe healthcare settings that are completely free of racism.

People-centred and responsive to family

Services should be focused on the needs of individuals rather than systems' requirements. Services also need to be responsive to the needs of prisoners' family members. For example, "where possible promoting and protecting the health and well-being of family members as part of the individual's health care and recovery plans, acknowledging the key roles family play in the individual's recovery journey, and successful reintegration into the community" (PMOC 2011: 7).

Essential (compulsory) mental health care

As the New Zealand Prison Model of Care for serious mental illness notes: "Compulsory mental health care of prisoners needs to take place in a timely fashion within a hospital setting, outside of the prison environment. Mental health of prisoners is a collaborative responsibility between health and corrections and requires sharing of strategic information to enable appropriate development for both services" (PMOC 2011: 6). Furthermore: "A multi-disciplinary approach (medical, social work, nursing, occupational therapy, cultural expertise, alcohol and other drug, psychological input) should be adopted across all culturally competent forensic prison mental health teams. A collaborative multi-agency approach (regional forensic mental health services, general mental health services, addiction services, community and social service agencies, correctional health teams, prison services, parole board and probation services, primary health organisations, etc.) must be supported by all key stakeholders." (PMOC 2011: 6-7). In the Australian context, the term compulsory may not be appropriate, however, seeing mental health as an essential focus of any health care of prisoners is critical.

Treatment and recovery paradigm

The delivery of health and wellbeing services needs to be based on a recovery paradigm, that is:

"*…focusing on each individual's journey that encompasses personal strengths, hope, medication/ treatment, empowerment, support, education/ knowledge, self-help, spirituality, employment/ meaningful activity and cultural identity. It is recognised that the prison setting is unique, and there will be challenges, however the essence of this principle remains paramount to the delivery of quality mental health services within this environment." (PMOC 2011: 7)*

Community equivalence of care

The quality and standard of mental and physical health care needs to be the same within prisons as it is in the broader community. This means treating all conditions in a timely manner and addressing the continuum of care, from prevention and health promotion, to screening and diagnosis, to acute care and urgent transfer, to management and ongoing care, which includes self-management (sees *Figure 16*).

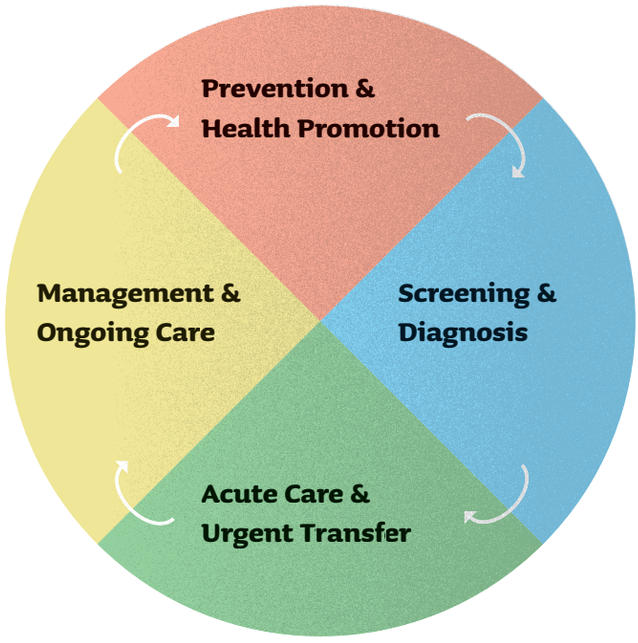

Figure 16 Continuum of care.

5. Model of Care for Aboriginal Prisoner Health & Wellbeing in South Australia (cont.)

Social and emotional wellbeing in prisons

Aboriginal concepts of health and wellness are often holistic, including social, cultural, emotional and community wellbeing as well as physical health:

Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities." (Swan and Raphael 1995, cited in Poroch 2007: 15)

Attending to the social and emotional wellbeing of Aboriginal and non-Indigenous prisoners requires that staff within prison settings interact with prisoners as individuals who are simultaneously family and community members.

Reducing recidivism

The final principle that guides this model is reducing recidivism, which brings the model into alignment with the Department for Correctional Services Strategic Policy Panel Report, Reducing Reoffending – 10% by 2020 (DCS 2016). In relation to health, the Panel recommended the following:

9. South Australian Prison Health to enhance prisoners' access to health services and ensure the delivery of medical plans on release, for prisoners requiring ongoing medical interventions.

5.3. Detailed Framework

The overarching design is supported by a detailed framework that summarises the principles, core elements, key considerations and facilitators of implementation (including community preparedness) for the model.

Principles

As described in section 5.2 above, the principles that guide this model include: (1) human rights and treatment of prisoners; (2) anti-racist prison cultures; (3) people-centred and responsive to family; (4) compulsory mental health care; (5) treatment and recovery paradigm; (6) community equivalence of care; (7) social and emotional wellbeing in prisons; and (8) reducing recidivism 10% by 2020.

Core elements

As described in section 5.3 above, the core elements include: (1) pre-release planning from entry into prison; (2) culture, spirit and identity; (3) communication; (4) access to and continuity of care; (5) family; (6) flexible pathways; (7) recovery, rehabilitation, therapy; and (8) person linked to community services.

Key considerations into key recommendations

Each of the core elements is supported by a number of key considerations that resulted from either the evidence review, consultations or both. These key considerations were then transformed into recommendations as a result of the findings of the stakeholder workshop. These recommendations are the key enablers for the implementation of the model of care. The final recommendations can be found in Section 6.1.

Facilitators of implementation

While implementation is out of scope for the Wardliparingga part of this project, nevertheless it was discussed extensively within the Stakeholder Reference Group meetings, the formal consultations and Stakeholder Workshop. Therefore, this report briefly describes some potential facilitators of implementation, and also recommends that SA Prison Health Service works with Department for Correctional Services and Aboriginal community Elders to develop an implementation and evaluation plan for the model. The facilitators of implementation include: (1) governance; (2) workforce and training; and (3) interagency links. Community preparedness is an ongoing process to prepare prisoners to return to the community, and to prepare the community to adequately support ex-prisoners. It is the shared responsibility of both SAPHS and DCS to ensure the former, while it is the responsibility of South Australia as a whole to promote the latter.

Governance and accountability

Improvements in governance and accountability between SAPHS and DCS are vital to successful implementation of this model. More appropriate cost sharing between Central Adelaide Local Health Network, which is responsible for SAPHS, and Country Health SA Local Health Network is vital for implementing the model also, particularly core elements such as access and continuity of care, flexible pathways, recovery, rehabilitation and therapeutic mental health care, and patient linked to community services. Appropriate governance also needs to actively involve Aboriginal community representatives, such as Elders, young people, formerly incarcerated and currently incarcerated people. Given that Aboriginal community Elders expressed strong concerns regarding accountability, clear monitoring and evaluation will be vital to the successful implementation of the model.

Workforce and training

Adjustments to the skill and knowledge mix of the prison health service workforce and additional training will also facilitate successful implementation. For example, ensuring a gender appropriate workforce within prison health services is crucial to providing culturally appropriate care. A pilot Aboriginal Health Practitioners in-reach program is scheduled to begin in July or August 2017, and will provide excellent information regarding increasing the Aboriginal workforce with SAPHS. The pilot is intended both to improve access and care for prisoners while in prison and to improve access and engagement with primary healthcare services upon release. A description of the scope of practice is provided in *Text Box 1* on the next page..

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Aboriginal Health Practitioner – Scope of practice

The Aboriginal Health Practitioner delivers high quality, culturally appropriate clinical care services to Aboriginal and Torres Strait Islander people and communities. Aboriginal Health Practitioner services may be delivered using varied approaches, with Aboriginal Health Practitioners functioning autonomously or as members of a multidisciplinary team. They are trained in clinical assessment, disease prevention and health promotion, undertaking clinical procedures and in the delivery of specific health care programs. Aboriginal Health Practitioners may work with Aboriginal infants, children, adults, families and communities across all stages of the life span. The Aboriginal Health Practitioners operates in various contexts including urban, regional, rural or remote settings. They may be employed to work in primary healthcare services, Aboriginal specific and mainstream, community settings, mental health settings or acute and rehabilitation hospitals. Depending on population and context, Aboriginal Health Practitioners may aim to achieve the following outcomes: promoting holistic health wellbeing and quality of life for communities and individuals: providing culturally safe clinical services; improving social and family relationships; ensuring the delivery of effective Aboriginal healthcare programs; addressing the social determinants of health; improving access to health services for Aboriginal people; and improving the health outcomes of Aboriginal people. The Australian Health Practitioner Regulation Agency (AHPRA), are responsible for the registration of Aboriginal Health Practitioners and have developed a range of professional standards, codes and guidelines to regulate the profession

Text Box 1. Aboriginal Health Practitioner – Scope of Practice.

There is a pressing need for cultural awareness and cultural competency training within all South Australian prison settings. Such training needs to be both broad and localised, and needs to involve Aboriginal people (e.g. Elders, ex-prisoners) in the design and delivery of any and all training. Further training for health and correctional staff and managers regarding the health needs and care requirements of Aboriginal people in South Australia will also facilitate the implementation of all elements of the model.

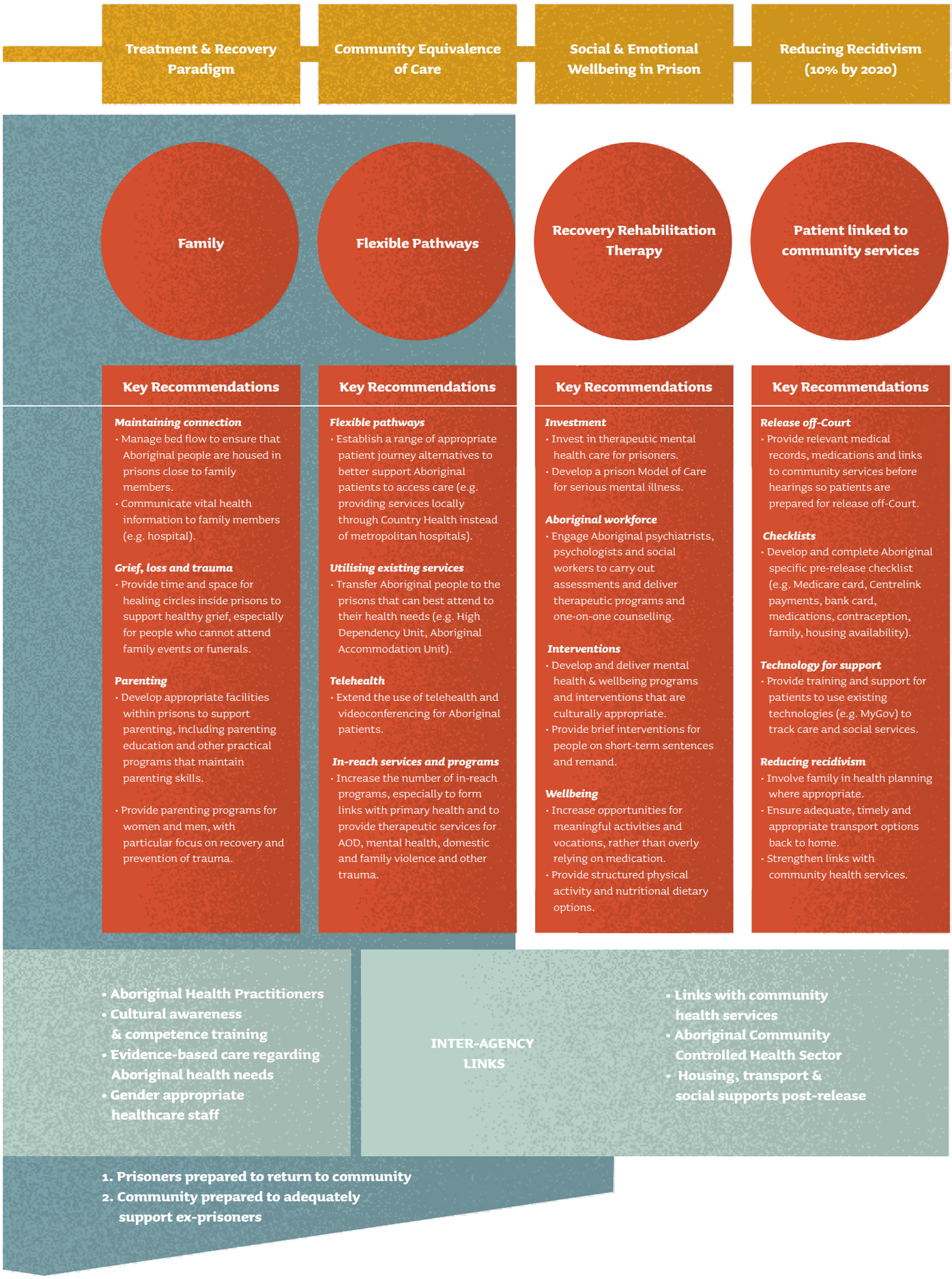
Interagency links

Shared responsibility and interagency links are also vital to successful implementation of the model. These may include strengthening formal and operational links between prisons and community healthcare services, including Aboriginal Community Controlled Health Services within prison locations and the communities that prisoners will return to upon release. Stronger links with agencies such as housing, transport and social services in the post-release setting will also facilitate successful implementation of core elements such as pre-release planning from entry and linking patients to community based services.

The detailed framework is provided in *Figure 17* on page 37 & 38.

Figure 16 Continuum of care.

Figure 17
South Australian Model of Care for Aboriginal Prisoner Health and Wellbeing – Detailed Framework


Treatment & Recovery Paradigm
Community Equivalence of Care
Social & Emotional Wellbeing in Prison
Reducing Recidivism (10% by 2020)
Family
Flexible Pathways
Recovery Rehabilitation Therapy
Patient linked to community services
Key Recommendations
Maintaining connection
· Manage bed flow to ensure that Aboriginal people are housed in prisons close to family members.
· Communicate vital health information to family members (e.g. hospital).
Grief, loss and trauma
· Provide time and space for healing circles inside prisons to support healthy grief, especially for people who cannot attend family events or funerals.
Parenting
· Develop appropriate facilities within prisons to support parenting, including parenting education and other practical programs that maintain parenting skills.
· Provide parenting programs for women and men, with particular focus on recovery and prevention of trauma.
Key Recommendations
Flexible pathways
· Establish a range of appropriate patient journey alternatives to better support Aboriginal patients to access care (e.g. providing services locally through Country Health instead of metropolitan hospitals).
Utilising existing services
· Transfer Aboriginal people to the prisons that can best attend to their health needs (e.g. High Dependency Unit, Aboriginal Accommodation Unit).
Telehealth
· Extend the use of telehealth and videoconferencing for Aboriginal patients.
In-reach services and programs
· Increase the number of in-reach programs, especially to form links with primary health and to provide therapeutic services for AOD, mental health, domestic and family violence and other trauma.
Key Recommendations
Investment
· Invest in therapeutic mental health care for prisoners.
· Develop a prison Model of Care for serious mental illness.
Aboriginal workforce
· Engage Aboriginal psychiatrists, psychologists and social workers to carry out assessments and deliver therapeutic programs and one-on-one counselling.
Interventions
· Develop and deliver mental health & wellbeing programs and interventions that are culturally appropriate.
· Provide brief interventions for people on short-term sentences and remand.
Wellbeing
· Increase opportunities for meaningful activities and vocations, rather than overly relying on medication.
· Provide structured physical activity and nutritional dietary options.
Key Recommendations
Release off-Court
· Provide relevant medical records, medications and links to community services before hearings so patients are prepared for release off-Court.
Checklists
· Develop and complete Aboriginal specific pre-release checklist (e.g. Medicare card, Centrelink payments, bank card, medications, contraception, family, housing availability).
Technology for support
· Provide training and support for patients to use existing technologies (e.g. MyGov) to track care and social services.
Reducing recidivism
· Involve family in health planning where appropriate.
· Ensure adequate, timely and appropriate transport options back to home.
· Strengthen links with community health services.
• Aboriginal Health Practitioners
• Cultural awareness & competence training
• Evidence-based care regarding Aboriginal health needs
• Gender appropriate healthcare staff
INTER-AGENCY LINKS
• Links with community health services
• Aboriginal Community Controlled Health Sector
• Housing, transport & social supports post-release
1. Prisoners prepared to return to community
2. Community prepared to adequately support ex-prisoners

5. Model of Care for Aboriginal Prisoner Health & Wellbeing in South Australia (cont.)

5.4. Priority Health Conditions

The evidence base for this model focuses on five priority health conditions for prisoners that were identified by the Australian Institute for Health and Welfare (AIHW): mental illness, chronic conditions, communicable diseases, substance use disorders and disability. It is noteworthy that these priority health needs were supported by the findings of the consultations as well, and that more detailed 'fact sheets' are presented in Appendix 8.

Mental illness

The findings from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991) identified support for mental health and treatments for mental illness as priorities for Aboriginal and Torres Strait Islander people in custody and in the broader community. However, there are very few studies that have investigated mental illness among Aboriginal and Torres Strait Islander people in prisons.

One study that investigated prevalence of mental illness was conducted in nine correctional centres across Queensland between May and June 2008 with 419 prisoners. It found that 86% of female and 73% of male Aboriginal prisoners had experienced at least one mental disorder within the previous 12-months (Heffernan et al 2012; see also Ober et al 2013). The breakdown by gender and disorder is shown in *Table 2* below.

Mental Illness	Female	Male
Anxiety disorders	51%	20%
Depressive disorders	29%	11%
Psychotic disorders	23%	8%
Substance misuse disorders	69%	63%

Table 2 Prevalence of mental illness for Aboriginal and Torres Strait Islander women and men in prison.

Given that the SA prison population is likely to be experiencing similarly high levels of mental illnesses, these results indicate an urgent need for culturally capable mental health services for Aboriginal and Torres Strait Islander people in custody. Queensland Health's Prison Mental Health Service provides in-reach mental health assessment and management to individuals in all major correctional centres in Queensland (Green et al 2016: 799). In South Australia, while the SA Department for Correctional Services employs social workers, psychologists and Aboriginal Liaison Officers, the South Australian Prison Health Service provides very little therapeutic mental health care. Forensic Mental Health Service provides service to forensic patients (i.e. those declared unfit for trial due to mental incompetence) and prisoners who are acutely unwell.

Mental illness is also associated with recidivism, the tendency of a convicted criminal to reoffend. For example, as described by Wood (2011), "Parolees with severe mental illness have been found to be more vulnerable to breaching parole conditions due to technical violations (e.g. failure to attend a scheduled appointment of serve notification of a new address, as well as testing positive for illicit substances) than their counterparts in the general custodial population" (Wood 2011: 176). Several innovative responses to mental illness within prison settings, from Australia and New Zealand, are described below.

Point-of-reception mental health screening

Point-of-reception mental health screening is a promising strategy to provide early opportunities to identify mental illness and begin treatment. In a 2009 Victorian study of 4229 male prisoners received into the main reception prison were screened using a modified Jail Screening Assessment Tool. Nineteen percent were identified as mentally ill and an additional 20% had a history of psychiatric illness requiring ongoing care. However, the study found that "no mentally ill prisoners were transferred to the state's forensic hospital and few were transferred to the prison's mental health unit, or provided support service referrals" (Schilders and Ogloff 2014: 480). This indicates that screening is of most value when follow-up services are available and utilised. Similarly, a review of actions taken in response to mental health screening at reception into prison found that "care pathways need to be defined, and screening needs to be delivered as originally intended by initial screen for life-threatening matters, followed by a later, comprehensive assessment of mental health needs" (Hayes et al 2014: 371).

Prison Model of Care (PMOC) for serious mental illness

A Prison Model of Care (PMOC) for serious mental illness was developed by forensic mental health and correctional services in New Zealand in 2011 to address the gap between detecting mental illness and translating that detection into higher rates of treatment by improving the consistency and quality of prison mental health in-reach care (Pillai et al 2016). The PMOC divides the care pathway into five steps (screening, referral, assessment, treatment and release planning), with associated standards and timeframes for subsequent activities (see NMRFMHS 2011). The results of a before and after review to describe the impact of the model on the proportion of prisoners receiving specialist mental health services found that the "PMOC led to increased prisoner numbers across screening, referral, treatment and engagement. Gains were achieved without extra resources by consistent processes and improved clarity of professional roles and tasks" (Pillai et al 2016: 9).

Aboriginal mental health staff and teams

Aboriginal teams within mainstream mental health settings have been shown to improve access and responsiveness of mental health services to Aboriginal patients. For example, the Aboriginal

Mental Health Team within South Australia's Rural and Remote Mental Health Service (RRMHS) comprised a dedicated consultant psychiatrist, senior registrar and senior Aboriginal cultural consultant who worked with other services staff. They found that "engagement has been also enhanced by having Aboriginal staff within the service, to 'open the doors' for Aboriginal patients, to vouch for the team and to assist in ensuring that the environment remains culturally safe. Our experience has underlined the importance of employing Aboriginal staff at key clinical service entry/exit points to liaise with the Aboriginal social, cultural and clinical networks" (Fielke et al 2009: s76).

Chronic conditions

Chronic diseases including cardiovascular disease (heart and stroke), cancer, diabetes, respiratory diseases and liver diseases contribute significantly to the proportion of deaths within the Aboriginal community. These five diseases alone account for almost two thirds of all deaths for Aboriginal people in South Australia (see *Figure 18*).

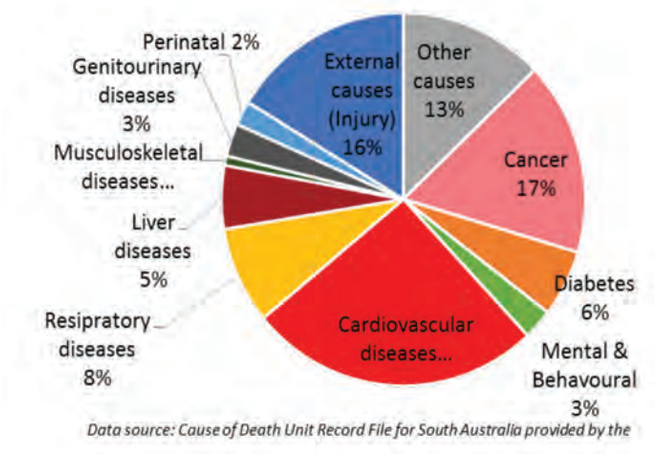


Figure 18 Aboriginal deaths by cause of death, South Australia, 2006-2012.

Aboriginal people in South Australia pass away from these chronic conditions at significantly younger ages compared to the non-Aboriginal population (see Figure 19). The greatest proportion of deaths occur between 40 and 70 for Aboriginal people, as opposed to 60+ for non-Aboriginal people.

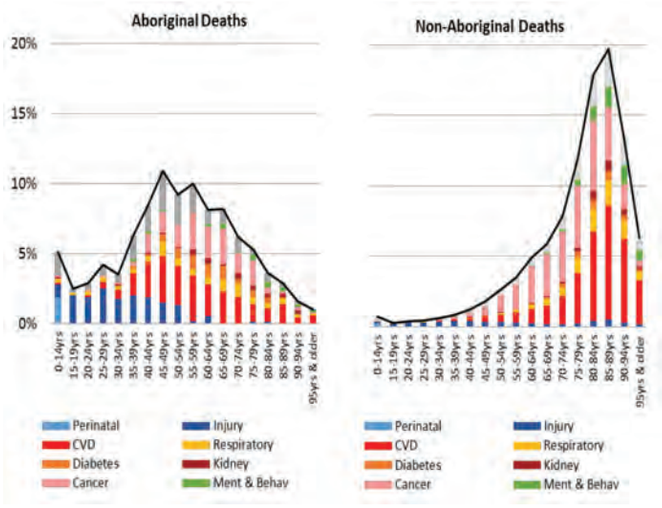


Figure 19 Proportion of deaths by cause of death, by Aboriginal status and age, South Australia, 2006-2012.

There are some interesting and innovative ways of managing chronic conditions within prison settings; in particular, three examples from the United States are described below.

Chronic Care Model – California, USA

The prison health care system in California adopted a modified version of the Chronic Care Model (CCM) in 2008 to improve timely access to safe, effective, and efficient medical care within its overcrowded prisons (Chang and Robinson 2011). The goals of the chronic care initiative were to improve access to care by creating standardised, measurable, reliable processes and protocols. Notably:

"the delivery system design, as part of the CCM [chronic care model], requires fundamental changes in clinical roles and the way business is conducted. It also requires recruiting and developing internal capacity for significant human resources to lead, manage and support the change process" (Chang and Robinson 2011: 174)

The private sector version of the CCM was revised to suit the custodial setting, in which healthcare needs are generally secondary to security requirements. Each of the model's six standard elements were revised as follows:

- **Delivery system design –** shifted from Californian prisons' single-provider approach to a patient-centred team model with the custody officer as a critical member; created new job classifications as a consequence of the heavily unionised workforce climate
- **Decision support –** evidence-based guidelines to support

5. Model of Care for Aboriginal Prisoner Health & Wellbeing in South Australia (cont.)

clinical practice were modified slightly to accommodate the prison environment; health education materials were modified to suit the vocabulary, reading levels of its diverse prison population

- **Clinical information systems –** Californian prisons only had paper records at the time of design (2008)
- **Self-management support –** challenging in a custodial setting where custodial concerns form an obstacle for patients to perform aspects of routine self-care
- **Community resources and policies –** care coordination, case management and discharge planning are critical to connect former prisoners with their communities and to ensure continuity of care
- **Health care organisation –** fiscal constraints prevented full adoption of the CCM in its optimal state
- **Local champions: catalysts for change –** included influential custodial staff, chief medical officers, nursing leaders to advocate for patient-centred care

Assessing chronic illness care in prison (ACIC-P) – United States

Related to the Chronic Care Model described above, the Assessment of Chronic Illness Care (ACIC) which is a tool to assist primary healthcare services to measure how well they are providing chronic illness care in each of the six components of the CCM, was recently adapted for prison settings by researchers in the United States (Wang et al 2014). Generally, the twelve health care providers and administrators involved in the study felt that the original ACIC was a useful tool, although somewhat aspirational rather than realistic for correctional health. They found that some of the terminology was not appropriate for correctional care settings, and that responses might vary depending on the security level of the institution (Wang et al 2014: 318). They adapted the tool, and the resulting ACIC-P includes additional elements such as planning for release back to the community. This adapted tool may be useful for measuring the adequacy of the provision of chronic disease care in South Australian prisons.

Self-managing chronic diseases and risk factors in prisons – Connecticut, USA

A recent qualitative study involving 26 people with cardiovascular disease (CVD) who recently had been released from prison in Connecticut in the United States explored these prisoners'/patients' experiences of managing CVD and risk factors while in prison This study recognise that custodial environments pose significant challenges for prisoners to 'self-manage' their chronic illnesses and found that: (1) patients perceived that their CVD risk factors were managed acutely rather than through chronic care processes; (2) prison providers' multiple correctional and medical roles can undermine patient-centred care; (3) informal support systems can enhance CVD risk factor management skills; and (4) the trade-off between prisoner security and patient autonomy influences opportunities for self-management (Thomas et al 2016: 1).

Communicable diseases

Incarcerated populations are known to be at much higher risk of contracting sexually transmitted infections and blood borne viruses, and there is a higher prevalence of STIs and BBVs compared to the general population (AMA 2017; Butler et al 2015; Watkins et al 2009). Unlike STIs which can only be transmitted via sexual contact, BBVs can also be transmitted via infected blood, exposure to contaminated blood products or injecting equipment, failures in infection control, unsafe tattooing or piercing practices, and mother to child transmission.

Priority populations for preventing, treating, and managing STIs and BBVs in Australia include Aboriginal and Torres Strait Islander people, people in custodial settings, and people who inject drugs. Despite this, over half of prisoners with a history of injecting are infected with Hepatitis C, including 8% who didn't know their Hep C status prior to entering the corrections system, and HIV prevalence is double that of the general population. The prevalence of Hepatitis C is similar for both Aboriginal and non-Aboriginal incarcerated populations (~30%), but Hepatitis B prevalence is much higher among Indigenous prisoners (25% vs 15%, 2013 data). The prevalence of syphilis, gonorrhoea and genital chlamydia in the prison population is much lower than Hepatitis B and C (1%, ,<1% and 4.5% respectively), but still higher than found in the general population (0.006% ,0.07% and 0.4% respectively), (http://www.abs.gov.au/socialtrends)

The Australian Medical Association has called for an improvement in health services within custodial settings, including the implementation of needle and syringe programs, and treatment regimens for BBVs. This is based on solid evidence that harm minimisation strategies are effective in custodial settings, for both prisoners and prison staff. It also decreases the risk of community infection post-release, with a reduced likelihood that someone will be discharged with an untreated infection.

Implementing evidence-based prevention, testing, treatment and management, and harm reduction strategies is crucial for decreasing the prevalence of STIs and BBVs in the incarcerated Indigenous population, which will also have a positive flow-on effect to the wider community. For example, implementing point of care testing machines in prison settings is an effective, affordable way of diagnosing STIs to provide timely treatment (http://who.int/reproductivehealth/topics/rtis/pocts/en/) (Natoli et al 2015).

The 2018-2020 suite of National Strategies for BBVs and STIs (Hepatitis Australia 2017) includes a separate strategy for responding to BBVs in prisons and other correctional settings, which covers the following:

- education about BBV transmission for inmates and staff
- access to confidential and culturally appropriate health services, including services delivered by Aboriginal and Torres Strait Islander people to Aboriginal and Torres Strait Islander people
- access to best practice BBV testing that is offered and provided by suitably trained health staff

- access to medicines used to treat and cure BBVs
- hepatitis B vaccination program for prison entrants
- ready access to sterile injecting equipment through prison-based exchange programs
- provision of bleach and disinfectant and education about their use
- access to opioid substitution therapy (OST) and other drug treatment and counselling services
- ready access to condoms and lubricant
- access to personal hygiene products including razors, toothbrushes and safe barbering equipment
- infection-control procedures to allow safe tattooing and body art

Furthermore, as per the AMA position statement (AMA 2017), it is recommended that:

- Correctional Services and prison health staff utilise evidence-based prevention strategies that reduce the risk of transmission of BBVs in custodial facilities, and establish a safer custodial environment for detainees and corrections staff, including regulated access to sterile injecting equipment (i.e. prison-based needle and syringe programs (NSPs)), to complement other harm minimisation measures.
- Prison health clinics develop strategies that ensure detainees and people who are in custodial facilities do not return to the community with undiagnosed and untreated BBVs.
- All people in custodial settings should have access to Medicare and PBS services, or the equivalent thereof.

Alcohol, nicotine and other drugs

Illicit drug offences make up 13% of all offences for the Australian prison population generally (Australian Bureau of Statistics, 2016). Such offences are more common amongst non-Indigenous prisoners compared to Indigenous (17% compared to 3%). However, more than half of all prison entrants (60% Indigenous, 69% non-Indigenous) report having used illicit drugs in the previous 12 months, with methamphetamine and cannabis the most commonly used substances. There are clear links between alcohol and other drug misuse and a range of violence and property offences leading to contact with the criminal justice system.

Entering prison can mean sudden withdrawal from drugs, and both detoxification (for withdrawal) and longer-term treatment may be required in prisons. Types of treatment for drug addiction provided in prisons and the corrections system vary from mandated residential drug treatment to counselling and pharmacotherapy.

Injecting drug use carries the risk of transmitting blood borne viruses such as hepatitis C and HIV through sharing needles and injecting equipment. Thirty-three per cent of Indigenous and non-Indigenous prison entrants have a diagnosis of hepatitis C. Rates of injecting drug use (IDU) amongst Indigenous prison entrants are high, with 46% reporting injecting in the previous 12 months. More than one-quarter (27%) of dischargees reported having injected drugs prior to being in prison, and 16% of all dischargees reported accessing needle and syringe exchange programs in the community (AIHW2015). As reported in the most recent report on prisoner health from the Australian Institute of Health and Welfare (AIHW), four per cent of dischargees reported using a needle and syringe that had been used by someone else, while in prison. A further 11% did not know if equipment they used had been used by someone else (AIHW 2015). These data were self-reported, therefore likely to be an underestimate.

The manner of release of a prisoner back into the community can represent one of the most critical factors for re-offending and community corrections services have a key role to play in reducing re-offending. Indigenous prisoners are more likely than their non-Indigenous counterparts to be readmitted to prison within two years (Bartels 2010). In the case of those with a history of harmful substance use, it is a time of great risk for substance use and overdose. One of the problems that Aboriginal prisoners also face is the loss of cultural identity and disconnection from their families. Therefore, connecting prisoners with their families and communities after release may be greatly beneficial in reducing the likelihood of re-offending. Measures supporting employment and stable housing, such as through reducing the barriers to employment associated with possession of a police record, may therefore have a positive impact on re-offending rates. Several potential responses to illicit drug use by prisoners are described below.

Needle and syringe programs

A review of international research and program development conducted by the University of NSW National Drug and Alcohol Research Centre in 2001 examined the successes and limitations of Needle Syringe Programs (NSPs) in a selection of prisons in Spain, Switzerland and Germany. All prisons surveyed reported a significant reduction in syringe sharing and it was almost non-existent at the end of most of the pilot studies. The review noted the limitations on the success of the program were based upon the knowledge and acceptance of the program among prisoners and staff, however, staff attitudes were mostly positive. No syringe-based attacks were reported in prisons that had implemented the NSPs (Rutter et al 2001). A proposal to pilot an NSP program in the Australian Capital Territory (ACT) was abandoned after receiving insufficient support from corrections staff, and there are currently no NSP programs operating in Australian prisons (Burdon 2017). Consequently, injecting equipment circulates in prisons as an informal and illegal economy, generating additional risk of transmission of BBVs (Treloar et al 2016).

Opiate Substitution Therapy

The availability of Opiate Substitution Therapy (OST) in prison has been associated with reduced drug injection in prison among those with a history of injecting drug use, which in turn reduces the associated needle sharing and infections (Kinner et al 2013). Adequate and effective OST in prison requires the provision

5. Model of Care for Aboriginal Prisoner Health & Wellbeing in South Australia (cont.)

of education alongside the OST, and an emphasis on linkages to community-based treatment (Schwitters 2014). In South Australia, Methadone and Buprenorphine treatment initiation and maintenance are available within prisons. Burprenorphine treatment initiated in prison has been shown to increase the likelihood that prisoners will enter treatment in the community upon release (Gordon et al 2014).

The National Indigenous Drug and Alcohol Committee

The National Indigenous Drug and Alcohol Committee (NIDAC) has identified the following opportunities for the Correctional System (NIDAC 2013)

- Providing comprehensive health screening on reception
- Encouraging the take-up of any treatment recommended after health screening
- Ensuring access to a full range of effective harmful substance use treatments, as well as mental health services, that are well suited to treating Indigenous offenders and their families
- Providing a continuum of health care and referral both within and beyond the correctional system
- Promoting the development of partnerships with Indigenous services, such as Aboriginal community-controlled health services and Aboriginal drug and alcohol services, to work in the correctional system
- Conducting national research into the health needs of and provision of appropriate and effective health services to, Indigenous offenders
- Instituting a national leadership forum to monitor and evaluate strategies introduced to reduce the level of Indigenous incarceration
- Instituting a trial of a needle and syringe program within an Australian correctional centre
- Providing all prisoners with access to free nicotine patches or other smoking cessation therapies

Disability and trauma

Hearing and ear health

Although not mentioned at all within the formal consultation settings, conversations with Aboriginal academics during the consultation period have emphasised the importance of hearing and ear health as a factor for Aboriginal offending, sentencing and incarceration, which are worth exploring in further depth. A study of 109 Indigenous people residing in five prisons in Victoria found that 12% had hearing loss in at least one ear (compared to 5% in age-matched Australian adults), more than a third (36%) had high-frequency sensorineural hearing impairment (symptoms of which include an inability to understand speech in noisy environments) in one or both ears, over half (58%) reported hearing problems sometimes, while 72% reported experiencing tinnitus (ringing in the ears) (Quinn and Rance 2009). As noted by Quinn and Rance (2009: 123): "For hearing impaired individuals within the correctional system, the reduced ability to communicate with ease may impact detrimentally on daily interactions, and may impede progress through rehabilitation programs."

Intellectual disability and foetal alcohol spectrum disorders

In addition, Aboriginal prisoners experience intellectual disabilities, including those associated with foetal alcohol spectrum disorders (FASD) and traumatic brain injuries, at higher rates than non-Indigenous counterparts. Prisoners with intellectual disabilities have a higher likelihood of being diagnosed with other medical conditions such as heart disease and hearing problems, and have worse health outcomes than their non-disabled peers (Dias et al 2012).

As noted within the Western Australia Education and Health Standing Committee report on foetal alcohol spectrum disorder, "FASD is the leading cause of non-genetic, intellectual disability in Australia and the Western World" (WA Legislative Assembly 2012: ii). FASD causes cognitive impairment; that is, an ongoing impairment in comprehension, reason, judgement, learning or memory, which may result in developmental delays, difficulty hearing, problems with vision, learning problems, language and speech deficits, impulsiveness, a short attention span, and difficulties getting along with others (WA Legislative Assembly 2012: foreword). The Committee was told that rates of FASD can be 30% or more of the population in some remote Aboriginal communities, but there is no clear prevalence data.

Traumatic brain injury

A South Australian population study found rates of traumatic brain injury at around 322 per 100,000 in the general population, with young males living in the country and working in manual trades showing the highest incidence (Hillier et al 1997), while a recent meta-analysis estimated the prevalence of traumatic brain injuries in incarcerated adults at 60.25% (Shiroma et al 2010). According to a longitudinal study of predictors of criminal arrest after traumatic brain injury, people who receive brain injuries with a loss of consciousness have been found to be at greater risk of future arrest (Elbogen et al 2015), suggesting a relationship between traumatic brain injuries and criminal behaviour (O'Rourke 2016).Traumatic brain injuries can manifest in a range of ways, including emotional and personality changes, impaired social function, aggression, lower short-term auditory-verbal memory and diminished executive function (O'Rourke 2016; Barnfield and Leathem 1998), and are associated with higher rates of substance use (Walker 2003).

It is noteworthy that female prisoners experience higher rates of traumatic brain injury than male prisoners (72% for females, 65% for males in a retrospective, cross-sectional cohort study of 320 males and 316 females in the US) (Ferguson et al 2012). Furthermore, a study of 113 female prisoners convicted of violent and non-violent crimes found that 95% of the sample had either neurologic histories predating the current crime or neurologic examination abnormalities, with 42% having experienced at least one traumatic brain injury with loss of consciousness; the majority of the injuries

were the result of violence perpetrated against the individual (Brewer-Smyth et al 2004). This study further found that violent criminal behaviour, including murder, by female prisoners was associated with the number of traumatic brain injuries with loss of consciousness, suicide attempts, and more recent abuse (Brewer-Smyth et al 2004).

Trauma and assault

Violent offenders, both female and male, have often been victims of abuse before their offences (Brewer-Smyth et al 2004). A qualitative study drawing on in-depth interviews with eleven high security male prisoners in Queensland identified a common trajectory for Aboriginal and non-Indigenous offenders, namely: childhood or adolescent trauma; lack of support or treatment for trauma experiences; substance abuse to mask the pain; and a 'brain snap' precipitating the violent offence (Honorato et al 2016). All of the participants in the study reported experiences of trauma in their childhood or adolescent, including: sexual abuse by family or others; family members being assaulted or sexually assaulted, kin committing suicide or being killed, and being subject to severe bullying. The study recommends early detection and intervention for trauma victims to reduce the likelihood of the trajectory from trauma to incarceration (Honorato et al 2016). As noted above, trauma in this context can include sexual abuse, as described by one participant in the Honorato et al (2016) study:

"And they put me in a dorm with older boys there who then abused me…And I couldn't do anything about it, I couldn't…" (Honorato et al 2016: 4)

Prevalence rates for childhood sexual assault are approximately 25% for females and 17% for males, and approximately 20% of sexual assaults are perpetrated by females (McLeod et al 2015). A personal history of sexual abuse is the strongest predictor for abuse against others in adulthood, and female sexual offenders are more likely to be involved in ongoing physical victimisation such as domestic abuse and intimate partner sexual assault (McLeod et al 2015). Therefore, "despite being perpetrators of sexual abuse, some of the primary characteristics shared by female sexual offenders are their extensive trauma histories and lifetime patterns of victimisation" (McLeod et al 2015: 935). While rates of sexual assault may be higher for females who later become incarcerated, males may be less likely to seek help or talk about the abuse and its effects, as illustrated by the following participants in the Honorato et al (2016) study:

"*Yeah, and I think the abuse and that, that I got there [boys home], I think that's why I first started smoking dope, yeah…and I didn't want to tell anyone [about the abuse] because it was so embarrassing.*" *(Honorato et al 2016: 5)*

"I had a problem but I never really talked to anyone. And I carried it around for years, I had like an anger problem and I don't know… Yeah, just sort of seemed to carry a lot of anger around, whin I should like, got help, to get me through it…And yeah, it was really hard." *(Honorato et al 2016: 4)*

"And then one day it was like 15 years after it happened, and one day I just sort of lost it, and yeah killed someone … I don't know, it was just like something snapped, I had no control over it…and when I realised what had happened I couldn't believe it, like… just something built up, built up and built up and just whoosh, come straight out…I've always had a problem with that…I bottle a lot of stuff up and I'm still trying to find ways of letting it out without taking it out on anyone else in front of me, you know." *(Honorato et al 2016: 6)*

In a study of victimisation and feelings of safety inside prison with 6964 male and 564 female inmates, those who felt most unsafe (n=150) reported sexual victimisation by staff or concurrent sexual and physical victimisation (Wolff and Shi 2011). Findings from all of these studies indicate the importance of prevention and treatment interventions for physical and sexual abuse (Brewer-Smyth et al 2004).

5.5. Defined standards

While the model does not prescribe which defined standards SA Prison Health Service should bind the model to within its implementation and evaluation plan, a number of existing standards are described below to provide guidance on possible opportunities for this component of the model.

Standard Guidelines for Corrections in Australia

All Australian jurisdictions are bound by the Standard Guidelines for Corrections in Australia (Australian Government 2012). Section two, Care and Wellbeing, details the guidelines in relation to number of categories including accommodation, religious and spiritual needs, psychological services and managing prisoners' stress and health services. Specifically, these Care and Wellbeing guidelines include the following:

- Indigenous prisoners should be allowed access, where possible, to Elders who are recognised as Elders or leaders of their community to address the emotional and spiritual needs of Indigenous prisoners (2.17).
- Spiritual beliefs and needs of Indigenous prisoners should be taken into account when managing the welfare of these groups of prisoners during times of individual, family or community crisis (2.20).
- Consideration may be given to the use of family or identified community members for the support of Indigenous and CALD prisoners to manage self-harm and other psychological issues or episodes (2.25).
- In the case of an Indigenous prisoner [upon death, serious illness or injury], the Aboriginal Legal Service and any Aboriginal spiritual advisers are also to be advised.

5. Model of Care for Aboriginal Prisoner Health & Wellbeing in South Australia (cont.)

National Safety and Quality Health Standards – Aboriginal Actions

In 2019, the National Safety and Quality Health Standards will include six new actions that focus specifically on meeting the needs of Aboriginal and Torres Strait Islander peoples, including Aboriginal and Torres Strait Islander people accessing prison health services (needs reference). These six actions and their associated standards are presented in *Figure 20* below.

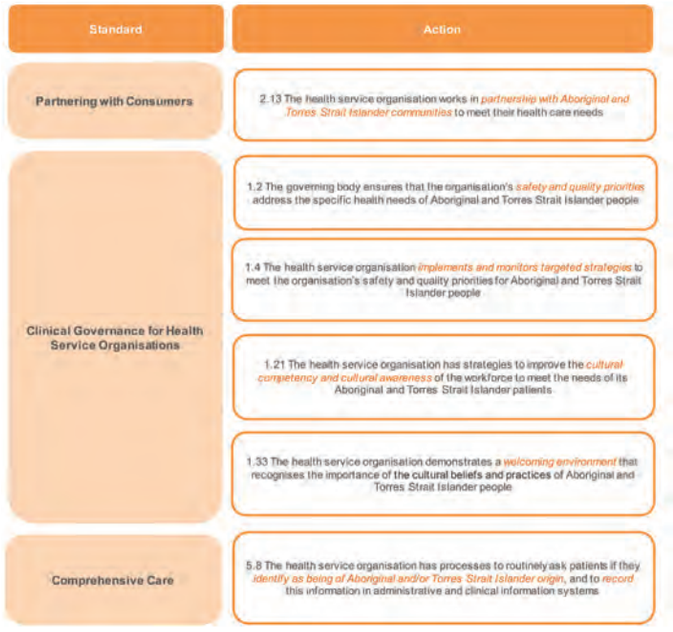


Figure 20 National Safety and Quality Health Service Standards – impending Aboriginal-specific actions.

These six Aboriginal specific actions can be approached in progressive steps. As such, it is recommended that SA Prison Health Service and Department for Correctional Services:

1. Develop partnerships with Aboriginal and Torres Strait Islander communities in South Australia.
2. Ensure Aboriginal and Torres Strait Islander people are part of the governance structures of all of the South Australian prisons to identify and prioritise health needs.
3. Undertake gap analyses to help inform strategies and understand the specific needs of the Aboriginal and Torres Strait Islander people who enter South Australian prisons.
4. Using the identified priorities, develop and implement strategies, with associated monitoring and evaluation systems in partnership with Aboriginal and Torres Strait Islander people through the governance structure. These should include strategies that address the remaining actions (i.e. identification, welcoming environments, cultural awareness and competence).
5. Maintain ongoing partnerships and Aboriginal and Torres Strait Islander representation on the governing body of South Australian prisons.

RACGP Standards for Health Services for Australian Prisoners

In 2011 the RACGP developed a set of standards for the delivery of health services to prisoners in five sections:

1. Services – including access to care, information about the health service, health promotion and prevention of disease, diagnosis and management of specific health problems, continuity of care, coordination of care, content of patient health records
2. Rights and needs of patients – including collaborating with patients
3. Safety, quality improvement and education – including safety and quality, education and training
4. Health service management – including health service systems, management of health information
5. Physical factors – including facilities and access, equipment for comprehensive care, clinical support processes (RACGP 2011).

However, there are some limitations to this document. Despite the significant health disparities between Aboriginal and non-Aboriginal peoples in the broader population and the higher rates of incarceration of Aboriginal and Torres Strait Islander people in all Australian jurisdictions, the RACGP standards focus on improving clinical prison health care using a mainstream approach rather than actively engaging with these significant disparities for Aboriginal prisoners. The entire 120 page document only mentions Aboriginal people five times; noting the much higher incarceration rate (p.3), referring readers to the Healthy for Life website for health promotion information for Aboriginal people (p.23), identifying an indicator that demonstrates that health services can access guidelines for the specific clinical care of patients who identify as Aboriginal (p.25), identifying an indicator that demonstrates that the health service is recording cultural background (e.g. Aboriginal) in their active patient health records (p.42) and identifying an indicator that demonstrates identification of significant cultural groups within the prison health service (p.49). While each of these aspects are mentioned, they are not packaged into a focused approach for Aboriginal prisoners.

6. Concluding Comments and Recommendations

The South Australian Model of Care for Aboriginal Prisoner Health and Wellbeing is compatible with Department for Correctional Services Strategic Policy Panel Report, Reducing Reoffending – 10% by 2020 (DCS 2016). In particular, the model of care reinforces the health, wellbeing and resilience quadrant of the Reducing Reoffending Framework that is shown in *Figure 21* below. It also supports the targeted and person centred, holistic approaches, reducing the risk of further harm, and will enable the following: connection to family and community; greater community understanding; specialist responses for specific groups; behaviour change programs; tackling of substance abuse; connection to spirituality, Country and culture; motivation and strength based approaches; life skills; and trauma informed care.

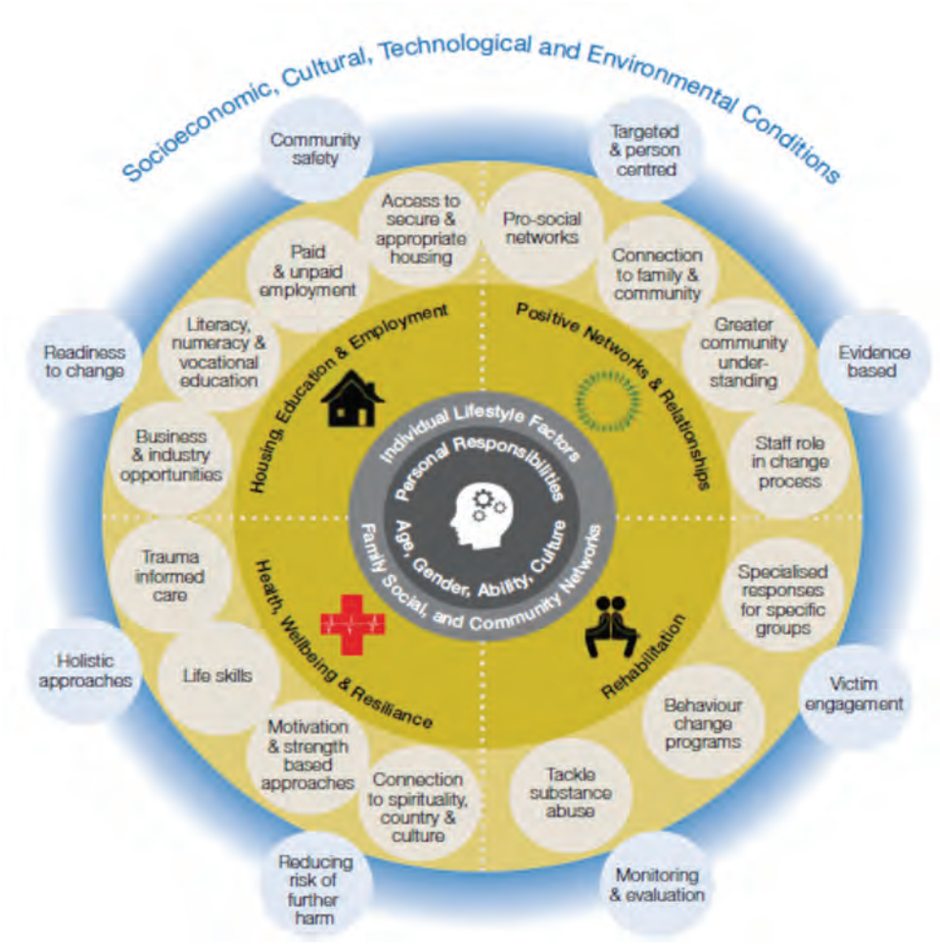


Figure 21 Reducing reoffending framework (Source: DCS 2016).

Implementing the South Australian Model of Care for Aboriginal Prisoner Health and Wellbeing will assist with the successful implementation of Reducing Reoffending Framework.

6. Concluding Comments and Recommendations (cont.)

6.1. Recommendations

The recommendations are organised by the core elements and facilitators of implementation within the overarching design, which is shown again in *Figure 22*.

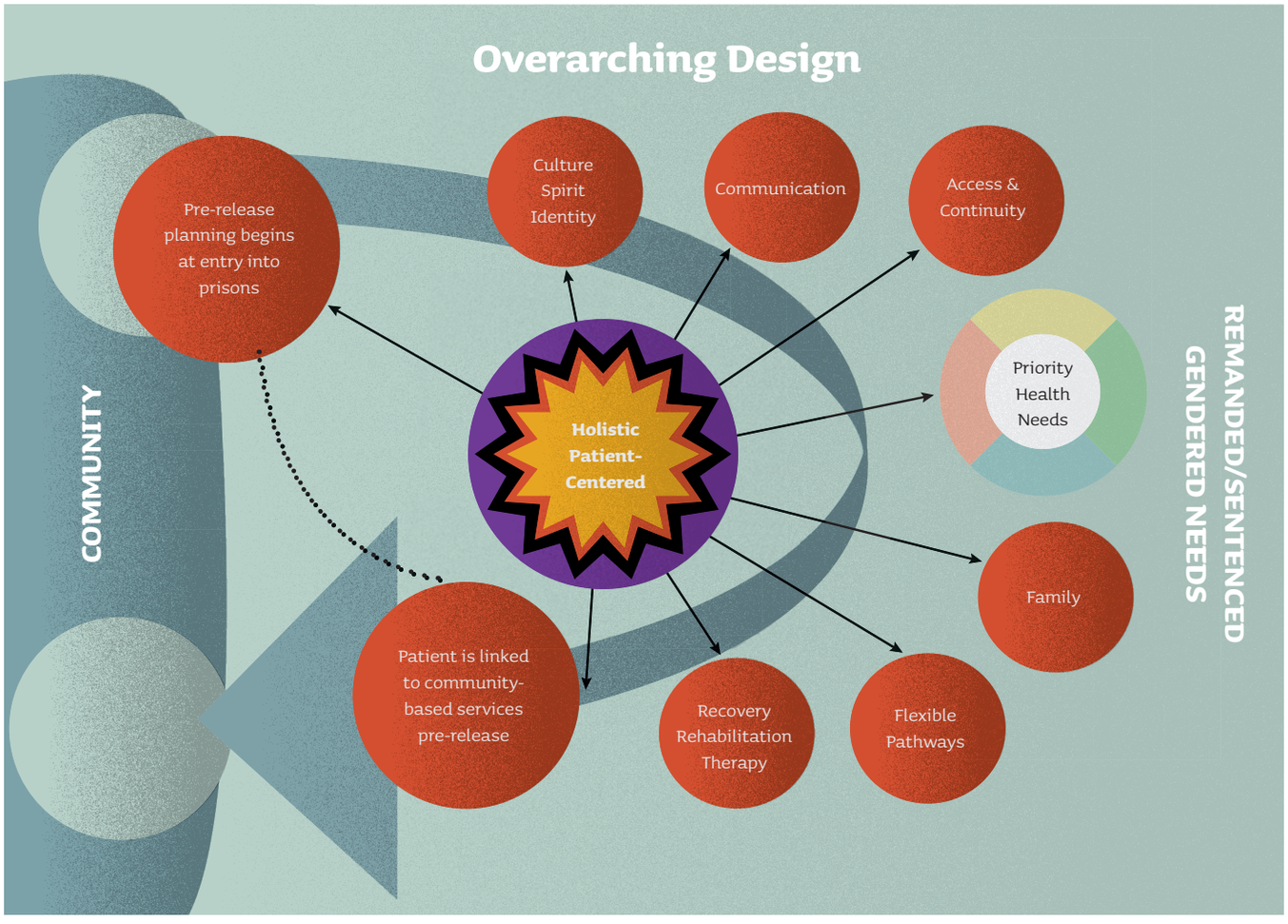


Figure 22 Overarching design: Model of Care for Aboriginal Prisoner Health and Wellbeing.

Recommendations to facilitate implementation of the model of care

1. It is recommended that the SAPHS adopt the SA Aboriginal Prisoner Health and Wellbeing Model of Care and plan for its implementation during 2018

Governance and accountability

2. Develop a joint SAPHS/DCS governance structure and implementation plan for the Model of Care, including appropriate input from LHNs, Aboriginal community representatives such as Elders, advocates and former prisoners.
3. Develop a detailed monitoring and evaluation approach for measuring the impact and outcomes of the Model of Care.
4. Develop appropriate cost sharing between Central Adelaide Local Health Network and Country Health SA Local Health Network to ensure access and continuity of care, flexible pathways, therapeutic mental health care and links to community services.

Workforce and training

5. Establish a strategy to ensure a gender-and culturally diverse Prison Health Service workforce to provide culturally appropriate care to all Aboriginal prisoners.
6. Work with relevant LHNs and appropriate ACCHOs to implement an Aboriginal Health Practitioners in-reach program in the short-term, with a goal to achieve a workforce that includes Aboriginal

Health Practitioners (within the SAPHS and from external agencies) at all South Australian prisons within 5 years.

7. Deliver ongoing cultural awareness and cultural competency training for all SAPHS and DCS staff within South Australian prison facilities; such training needs to be both general in nature and specifically tailored to local community connections and culture. This would include a state-wide consistent approach that is designed by Aboriginal people skilled and experienced in the delivery of such training. Involvement of local community in ongoing cultural training would be encouraged.
8. Ensure SAPHS and DCS staff have training and awareness of racism as impacting on health and wellbeing.
9. Ensure all Prison Health Service and Correctional Services staff have access to regular briefings/updates on the specific health needs, emerging issues and evidence and associated care requirements of Aboriginal people in South Australia.
10. Provide training and support for SAPHS and prisoners to use existing technologies (e.g. MyGov) to track health care and other services and entitlements.

Interagency links

11. Strengthen formal and operational links between prisons and their local community healthcare services, including Aboriginal Community Controlled Health Services and ensure staff are aware of the local primary care and other specialist health services that prisoners may need for ongoing care after release into the community.
12. Ensure staff who facilitate release of prisoners are aware of the health needs of the prisoner upon release and are able to access information on agencies such as housing, transport and social services in the post-release setting to improve pre-release planning from entry and direct patients to community services.

Pre-release planning begins at entry into prison

13. Review the initial assessments of health needs conducted on entry of all Aboriginal people into prison/remand, to ensure a comprehensive medical and wellbeing assessment is able to be conducted. The review would assess current processes, capacity, systems, and workforce and map a planned approach to reaching a "best-practice" approach to assessment, care planning and health and wellbeing management and support.
14. Review current practices for release of Aboriginal prisoners as it relates to transition of their health care to a primary care service/practitioner. Effective transition will require coordination across SAPHS, DCS and relevant community based and in-reach social and health services from first entry to prepare for return to community.

Culture, spirit identity

15. Establish a Working Group to consider and make recommendations on the recognition, active support and strengthening of cultural identity and spiritual health of Aboriginal prisoners. This would involve consideration of: spiritual health cultural care, kinship care, Ngangkari and other Traditional Healer services, grief and loss support, healing circles and peer support between prisoners and by Aboriginal health and support staff.

Communication

16. Develop a program of health literacy improvement amongst Aboriginal prisoners to improve prisoners' understandings of their diagnoses, decisions and processes of care and support self-management.
17. Ensure appropriate interpreter services are available in all prisons to assist SAPHS staff with promoting better understanding and compliance with treatments for Aboriginal prisoners for whom English is not spoken or is a second language.

Access and continuity

18. Extend eligibility criteria for all health services and programs to Aboriginal prisoners on remand or with short-term sentences.
19. Ensure information is sought from prisoners about their usual primary care service/practitioner to improve access to prisoner's pre-prison health and mental health histories and for appropriate transition after release.
20. Support a DCS review the current system of prisoner movements and their impact on disruption to a person's privileges (e.g. cellmate, job, security rating, etc.) while accessing health care externally.

Family

21. Develop a procedure for improved communication of vital health information to family members as soon as is practicable (e.g. hospital visits), taking into account privacy issues and practicalities.
22. Consult with Aboriginal prisoners and community members regarding improved support for grieving, especially for prisoners who cannot attend family events or funerals.
23. Develop appropriate facilities within prisons to support parenting, including parenting education and other practical programs that maintain parenting skills
24. Consult with Aboriginal women in the community and prisoners regarding advocacy for prison alternatives for women who may have to give birth in prison

6. Concluding Comments and Recommendations (cont.)

Flexible pathways

25. Establish facilities in all prisons to support the use of telehealth and videoconferencing for Aboriginal prisoners to access specialist assessments, treatments and care and avoid unnecessary, costly and disruptive transfers.

26. Increase the number of in-reach programs, especially to form links with primary health and to provide therapeutic services for alcohol and other drug misuse mental illness, domestic and family violence and other trauma.

Recovery, rehabilitation, therapy

27. Investigate, plan and implement a comprehensive therapeutic mental health care service within the SAPHS, using the New Zealand Model of Care as a reference point, ensuring cultural appropriateness for the Aboriginal prisoner population and including:

a. Brief mental health interventions for people on short-term sentences and remand.

b. Increased opportunities for mental health maintenance including meaningful activities and vocations.

28. Prepare and implement a chronic and communicable disease strategy for primary and secondary prevention, ongoing self-management, evidence-based health support (including structured physical activity and nutritional dietary options) and high quality medical and allied health services for prisoners with heart disease, diabetes, respiratory conditions, kidney disease, communicable diseases and common mental illnesses.

29. Prepare and implement disability support programs through the use of physiotherapists, occupational therapists and exercise physiologists and ensure daily care needs can be met for Aboriginal prisoners with day to day care needs.

Prisoners linked to community based services pre-release

30. Develop systems and procedures to ensure relevant medical records, medications and links to community services are prepared for all prisoners prior to court hearings to facilitate effective transition of health care and wellbeing if prisoners are released off-Court including development of a checklist to cover:

a. Entitlements - Medicare number and card, Centrelink status

b. Access to finances

c. Access to medications, including contraception

d. Contacts for primary health care and specialist support

e. Housing

f. Transport

Furthermore, Appendix 4 demonstrates how, if SAPHS and DCS work together to implement these 49 recommendations, they will also facilitate the implementation of 23 of the 33 recommendations from the Department for Correctional Services Strategic Policy Panel Report, Reducing Reoffending – 10% by 2020, as well as at least 20 of the 339 recommendations from the Royal Commission into Aboriginal Deaths in Custody.

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APPENDIX 1
Abbreviations

ACT	Australian Capital Territory
A/GM	Acting General Manager
AHP	Aboriginal Health Practitioners
AIHW	Australian Institute for Health and Welfare
ALO	Aboriginal Liaison Officer
CALHN	Central Adelaide Local Health Network
DCS	Department Correctional services
FASD	Foetal alcohol spectrum disorder
GM	General Manager
IDU	Injecting Drug Use
MOD	Manager for Offender Development
NALHN	Northern Adelaide Local Health Network
NDIS	National Disability Insurance Scheme
NIDAC	National Indigenous Drug and Alcohol Committee
NSPs	Needle Syringe Programs
NSQHS	National Safety and Quality Health Service
NUM	Nurse Unit Manager
OST	Opiate Substitution Therapy
PBS	Pharmaceutical Benefits Scheme
RACGP	Royal Australian College of General Practitioners
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SAHMRI	South Australian Health and Medical Research Institute
SAPHS	South Australian Prison Health Service
The Accord	South Australian Aboriginal Health Research Accord
UN	The United Nations
Wardliparingga	Wardliparingga Aboriginal Health Research Unit, SAHMRI

APPENDIX 2
Project Response to the Accord

Wardliparingga Aboriginal Health Research Unit at the South Australian Health and Medical Research Institute (SAHMRI) was engaged by South Australian Prisoner Health Service (SAPHS) to design a **model of care** that attends to the broad needs of the Aboriginal adult prison population (male and female) across South Australia. The project duration was 3 January to 30 June 2017. The project was overseen by a Stakeholder Reference Group consisting of representatives from: SA Prison Health Service (SAPHS), Department of Correctional Services (DCS), Grannies Group, Central Adelaide Local Health Network (CALHN), Northern Adelaide Local Health Network (NALHN) and the project team at Wardliparingga.

As signatories of the South Australian Aboriginal Health Research Accord (the Accord), all Wardliparingga projects must adhere to the nine principles of the Accord, which include: Aboriginal priorities, involvement, partnership, respect, communication, reciprocity, ownership, control, and knowledge translation. The following table describes how the Model of Care for Aboriginal Prisoner Health and Wellbeing project addressed the principles of the Accord. This 'project response' column was drafted at the beginning of the project, then reviewed again at the completion of the project, the final activities of which are detailed in the 'project completion' column.

PRINCIPLE	PROJECT RESPONSE	PROJECT COMPLETION
PRIORITIES: Research should be conducted on priorities arising from and endorsed by the Aboriginal community to enhance acceptability, relevance and accountability.	• Wardliparingga was approached by SA Health to assist in developing a model of care for Aboriginal prisoner health on the basis of: (1) community expressing a need for better health care within prisons, (2) the recent creation of an Aboriginal Health Practitioner role within SAPHS , and (3) a desire to further increase the Aboriginal workforce within SA prisons • In order to ensure acceptability, relevance and accountability to the community, the project is: (1) engaging community representatives onto the Reference Group for overall guidance and oversight of the project, and (2) consulting with selected community groups to ensure community-based perspectives are incorporated into the project design and outputs	• Community representatives were invited onto the Stakeholder Reference Group, which met monthly for the duration of the project. • Consultation with selected community groups – e.g. Grannies Group, DCS Aboriginal Elders Visiting Program – occurred to ensure community-based perspectives were captured
INVOLVEMENT: The involvement of Aboriginal people and organisations is essential in developing, implementing and translating research.	• Aboriginal individuals and organisations will be involved in the project in the following ways: (1) eight of the twelve members of the Reference Group are Aboriginal people with a range of perspectives including clinicians, community advocates, project staff and managerial roles within DCS and SA Health, (2) seven of the eleven members of the core research/project team are Aboriginal people with a range of expertise including clinical, policy and project skills, and (3) every attempt will be made to engage Aboriginal staff within DCS and SAPHS during the consultation activities and stakeholder workshops to ensure that the resulting model of care is relevant and appropriate, as well as able to be implemented into practice at the completion of the project • It is noteworthy that 'consumers' (i.e. current or past prisoners) will not be directly engaged by Wardliparingga in this project – this is because as a contract piece that has not received formal ethics approval by the Aboriginal Health Research Ethics Committee, the project team is only permitted to 'consult', not to conduct primary research. SA Health and/or SAPHS may decide to conduct consumer engagement (as per Standard Two – Partnering with Consumers) in parallel to this project; if appropriate, findings from such engagement may be included in the analysis	• The Stakeholder Reference Group met monthly throughout the project, providing opportunities for Aboriginal people to provide a range of perspectives on the development of the model. • The project team at Wardliparingga met on a regular basis, providing feedback during the design phase of the model of care. • The project team consulted with Aboriginal and non-Indigenous staff within DCS and SAPHS. • A Stakeholder Workshop was held to further consult with Aboriginal staff from across other departments and the NGO sector to ensure the model is appropriate and can meet the needs of Aboriginal people currently incarcerated. • Within the project timeframe, SAPHS staff – including the Project Officer for the model of care project – carried out two consumer feedback sessions with twelve Aboriginal people (six female, six male) currently incarcerated in SA prisons. The findings from the consumer feedback sessions were used to develop the model.

PRINCIPLE	PROJECT RESPONSE	PROJECT COMPLETION
PARTNERSHIP: Research should be based on the establishment of mutual trust, equivalent partnerships and the ability to work competently across cultures.	• Both the Reference Group and the Wardliparingga-based project team include Aboriginal and non-Indigenous people with a range of expertise, as well as demonstrated ability to work competently across cultures in this delicate and often stigmatised space of prisoner health • It is expected that both-way learning will be a key feature of all project activities as team members share information, experiences and understandings of the literature, consultation findings and development of the model of care	• As per Project Response
COMMUNICATION: Communication must be culturally and community relevant and involve a willingness to listen and learn.	• Communication procedures have been developed to ensure that consistent information is provided to external stakeholders • Regular team meetings (weekly) and Reference Group meetings (monthly) will ensure that all parties are kept informed of all activities, preliminary findings and any changes to the project in a timely manner • The inclusion of community members on the Reference Group will assist the project team to ensure appropriate language use in all correspondence and reporting	• A Communications Plan was developed and endorsed by the Stakeholder Reference Group. • Approved communication materials (e.g. information sheets) were provided to external stakeholders as necessary. • Team meetings where held on a regular basis to ensure all parties where kept informed of the progression of the project. • Community members where included on the Stakeholder Reference Group and played an active role in the reference group meetings to ensure appropriate language was applied to the processes and reporting.
RECIPROCITY: Research should deliver tangible benefits to Aboriginal communities. These benefits should be determined by Aboriginal people themselves and consider outcomes and processes during, and as a result of, the research.	• It is expected that the model of care that results from this study will be directly applied to shaping policy and practice within the SAPHS • As such, it is expected that health care delivery and resulting health outcomes for Aboriginal adult prisoners in South Australia will improve as the model of care is implemented • In addition, the model of care will assist with the defining of a scope of practice for newly formed roles for Aboriginal Health Practitioners within SAPHS, and will assist SAPHS to increase its Aboriginal workforce in a conscious and supported way • All processes as part of this project involve Aboriginal stakeholders and team members in all aspects of the project – it is expected that both-way learning will characterise all project activities	• The project team will offer feedback sessions to the Grannies Group, DCS Aboriginal Elders Visiting Program and Aboriginal communities more broadly following the completion of the project to describe the processes and outcomes of the model of care project. • The project team will also offer in-service training to SAPHS and DCS staff and management at the completion of the project, with a particular focus on preparing staff to implement the model of care.

PRINCIPLE	PROJECT RESPONSE	PROJECT COMPLETION
OWNERSHIP: Researchers should acknowledge, respect and protect Aboriginal intellectual property rights and transparent negotiation of intellectual property use and benefit sharing should be ensured.	• As per Wardliparingga Intellectual Property policy, all data will remain the property of individual participants or their affiliated organisations (where relevant) and we will seek license to utilise that information to conduct the project and answer the proposed questions, report findings and provide information that informs and supports communities • In order to ensure that project results are communicated accurately within the public domain at the completion of the project, Wardliparingga will request permission to publish the resulting model of care prior to implementation	• As per Project Response.
CONTROL: Researchers must ensure the respectful and culturally appropriate management of all biological and non-biological research materials.	• In this project, "data" are primarily comprised of written notes from consultation activities, supplemented with published and grey literature in the public domain • Individuals who participate in consultations or as stakeholders will be de-identified prior to publication or circulation of public materials	• All data obtained during consumer feedback sessions has been de-identified.
KNOWLEDGE TRANSLATION: Sharing and translation of knowledge generated through research must be integrated into all elements of the research process to maximise impact on policy and practice.	• As this project is contracted by SA Health, the results will belong to SA Health to implement, evaluate and translate as it believes appropriate • It is hoped that the model of care resulting from this study will directly influence policy development within SAPHS regarding prisoner health care and Aboriginal workforce • Wardliparingga may request permission to publish the resulting model of care in academic settings (journals, conference proceedings), but would only do so with the express permission of the Reference Group and all relevant stakeholders who would have input into how organisations are represented in publications	• As per Project Response.

APPENDIX 3
Culturally Appropriate Care Model

The Wellbeing Framework for supporting primary healthcare services to provide appropriate care for Aboriginal people with chronic disease (Davy et al. in press) was adapted for the South Australian Aboriginal Heart and Stroke Plan 2017-2021 (Wardliparingga 2016a). The adapted Wellbeing Framework (below) illustrates the necessary components of culturally appropriate care. This model underpins all aspects of the Model of Care for Aboriginal Prisoner Health and Wellbeing for South

APPENDIX 4
Recommendations and Royal Commission Into Aboriginal Deaths in Custody

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
Governance and Accountability		
2. The implementation will require the combined strategic commitment and efforts of the SAPHS and the Department for Correctional Services and the inclusion of Aboriginal stakeholders to ensure successful implementation. 3. Develop a detailed monitoring and evaluation approach for measuring the impact and outcomes of the Model of Care. 4. Develop appropriate cost sharing between Central Adelaide Local Health Network and Country Health SA Local Health Network to ensure access and continuity of care, flexible pathways, therapeutic mental health care and links to community services.	26. Maintain links with the Chief Executive Group for Aboriginal affairs as a forum for critical discussion on issues, policies and programs affecting Aboriginal Offenders. 28. Continue to strengthen partnerships with Aboriginal businesses and community organisations. 14. Ensure resources and programs are targeted, evidenced-based and focus on cohorts which will provide the best return for investment. 17. Ensure all programs are rigorously monitored and evaluated. 23. Develop a strategic framework for Aboriginal offenders. The framework must be founded on rigorous examination of issues facing Aboriginal offenders and be results based.	2. That subject to the adoption by governments of this recommendation and the concurrence of Aboriginal communities and appropriate organisations, 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.

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
Workforce and Training		
5. Establish a strategy to ensure a gender- and culturally diverse Prison Health Service workforce to provide culturally appropriate care to all Aboriginal prisoners. 6. Work with relevant LHNs and appropriate ACCHOs to implement an Aboriginal Health Practitioners in-reach program in the short-term, with a goal to achieve a workforce that includes Aboriginal Health Practitioners (within the SAPHS and from external agencies) at all South Australian prisons within 5 years. 7. Deliver ongoing cultural awareness and cultural competency training for all SAPHS and DCS staff within South Australian prison facilities; such training needs to be both general in nature and specifically tailored to local community connections and culture. This would include a state-wide consistent approach that is designed by Aboriginal people skilled and experienced in the delivery of such training. Involvement of local community in ongoing cultural training would be encouraged. 8. Ensure SAPHS and DCS staff have training and awareness of racism as impacting on health and wellbeing. 9. Ensure all Prison Health Service and Correctional Services staff have access to regular briefings/updates on the specific health needs, emerging issues and evidence and associated care requirements of Aboriginal people in South Australia. 10. Provide training and support for SAPHS and prisoners to use existing technologies (e.g. MyGov) to track health care and other services and entitlements.	30. Review opportunities to expand and enhance staff training to improve understanding of the complex composition of South Australia's offending population	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

APPENDIX 4
Recommendations and Royal Commission Into Aboriginal Deaths in Custody (cont.)

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
Interagency Links		
11. Strengthen formal and operational links between prisons and their local community healthcare services, including Aboriginal Community Controlled Health Services and ensure staff are aware of the local primary care and other specialist health services that prisoners may need for ongoing care after release into the community. 12. Ensure staff who facilitate release of prisoners are aware of the health needs of the prisoner upon release and are able to access information on agencies such as housing, transport and social services in the post-release setting to improve pre-release planning from entry and direct patients to community services.	33. Set up an advisory group to develop appropriate mechanisms to enhance service coordination, information sharing and data collection processes. 4. Develop a stable housing model to support prisoners release to appropriate accommodation. 35. Develop and implement a multi-agency, cross-government strategy to prevent crime and reduce reoffending. 36. The Department for Communities and Social Inclusion and DCS should seek to enhance information sharing at the individual and system levels to contribute to a reduction in reoffending. 13. Develop partnerships with local business sector.	N/A

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
Pre-release planning begins at entry into prison		
13. Review the initial assessments of health needs conducted on entry of all Aboriginal people into prison/remand, to ensure a comprehensive medical and wellbeing assessment is able to be conducted. The review would assess current processes, capacity, systems, and workforce and map a planned approach to reaching a "best-practice" approach to assessment, care planning and health and wellbeing management and support. 14. Review current practices for release of Aboriginal prisoners as it relates to transition of their health care to a primary care service/practitioner. Effective transition will require coordination across SAPHS, DCS and relevant community based and in-reach social and health services from first entry to prepare for return to community.	22. Ensure the specific and cultural needs of Aboriginal offenders are included in the implementation of panel recommendations.	171. That Corrective Services give recognition to the special kinship and family obligations of Aboriginal prisoners which extend beyond the immediate family and give favourable consideration to requests for permission to attend funeral services and burials and other occasions of very special family significance

APPENDIX 4
Recommendations and Royal Commission Into Aboriginal Deaths in Custody (cont.)

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
Culture, Spirit, Identity		
15. Establish a Working Group to consider and make recommendations on the recognition, active support and strengthening of cultural identity and spiritual health of Aboriginal prisoners. This would involve consideration of: spiritual health cultural care, kinship care, Ngangkari and other Traditional Healer services, grief and loss support, healing circles and peer support between prisoners and by Aboriginal health and support staff.	22. Ensure the specific and cultural needs of Aboriginal offenders are included in the implementation of panel recommendations.	171. That Corrective Services give recognition to the special kinship and family obligations of Aboriginal prisoners which extend beyond the immediate family and give favourable consideration to requests for permission to attend funeral services and burials and other occasions of very special family significance

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
Communication		
16. Develop a program of health literacy improvement amongst Aboriginal prisoners to improve prisoners' understandings of their diagnoses, decisions and processes of care and support self-management. 17. Ensure appropriate interpreter services are available in all prisons to assist SAPHS staff with promoting better understanding and compliance with treatments for Aboriginal prisoners for whom English is not spoken or is a second language.	27. Ensure translation services are provided for Aboriginal offenders who do not speak English as their first language. 34. Support DCS to commission partnerships with government, non-government and private agencies to provide services that are accountable, managed for results and deliver on the Panel's recommendations.	134. That police instructions should require that, at all times, police should interact with detainees in a manner which is both humane and courteous. Police authorities should regard it as a serious breach of discipline for an officer to speak to a detainee in a deliberately hurtful or provocative manner 99. That legislation in all jurisdictions should provide that where an Aboriginal defendant appears before a Court and there is doubt as to whether the person has the ability to fully understand proceedings in the English language and is fully able to express himself or herself in the English language, the court be obliged to satisfy itself that the person has that ability. Where there is doubt or reservations as to these matters proceedings should not continue until a competent interpreter is provided to the person without cost to that person 249. That the non-Aboriginal health professionals who have to serve Aboriginal people who have limited skills in communicating with them in the English language should have access to skilled interpreters "130. That a. Protocols be established for the transfer between Police and Corrective Services of information about the physical or mental condition of an Aboriginal person which may create or increase the risks of death or injury to that person when in custody;

APPENDIX 4
Recommendations and Royal Commission Into Aboriginal Deaths in Custody (cont.)

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
	Communication (cont.)	
		b. In developing such protocols, Police Services, Corrective Services and health authorities with Aboriginal Legal Services and Aboriginal Health Services should establish procedures for the transfer of such information and establish necessary safe-guards to protect the rights of privacy and confidentiality of individual prisoners to the extent compatible with adequate care; and c. Such protocols should be subject to relevant ministerial approval.
		131. That where police officers in charge of prisoners acquire information relating to the medical condition of a prisoner, either because they observe that condition or because the information is voluntarily disclosed to them, such information should be recorded where it may be accessed by any other police officer charged with the supervision of that prisoner. Such information should be added to the screening form referred to in Recommendation 126 or filed in association with it
		250. That effective mechanisms be established for communicating vital information about patients, between the mainstream and Aboriginal community-based health care services. This must be done in an ethical manner, preserving the confidentiality of personal information and with the informed consent of the patients involved. Such communication should be a two-way process

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
Access and continuity		
18. Extend eligibility criteria for all health services and programs to Aboriginal prisoners on remand or with short-term sentences. 19. Ensure information is sought from prisoners about their usual primary care service/practitioner to improve access to prisoner's pre-prison health and mental health histories and for appropriate transition after release. 20. Support a DCS review the current system of prisoner movements and their impact on disruption to a person's privileges (e.g. cellmate, job, security rating, etc.) while accessing health care externally.	N/A	150. That the health care available to persons in correctional institutions should be of an equivalent standard to that available to the general public. Services provided to inmates of correctional institutions should include medical, dental, mental health, drug and alcohol services provided either within the correctional institution or made available by ready access to community facilities and services. Health services provided within correctional institutions should be adequately resourced and be staffed by appropriately qualified and competent personnel. Such services should be both accessible and appropriate to Aboriginal prisoners. Correctional institutions should provide 24 hour a day access to medical practitioners and nursing staff who are either available on the premises, or on call 156. That upon initial reception at a prison all Aboriginal prisoners should be subject to a thorough medical assessment with a view to determining whether the prisoner is at risk of injury, illness or self-harm. Such assessment on initial reception should be provided, wherever possible, by a medical practitioner. Where this is not possible, it should be performed within 24 hours by a medical practitioner or trained nurse. Where such assessment is performed by a trained nurse rather than a medical practitioner then examination by a medical practitioner should be provided within 72 hours of reception or at such earlier time as is requested by the trained nurse who performed such earlier assessment, or by the prisoner. Where upon assessment by a medical practitioner, trained nurse or such other person as performs an assessment within 72 hours of prisoners' reception it is believed that psychiatric assessment is required then the Prison Medical e should ensure that the prisoner is examined by a psychiatrist at the earliest possible opportunity. In this case, the matters referred to in Recommendation 151 should be taken into account

APPENDIX 4
Recommendations and Royal Commission Into Aboriginal Deaths in Custody (cont.)

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
Family		
21. Develop a procedure for improved communication of vital health information to family members as soon as is practicable (e.g. hospital visits), taking into account privacy issues and practicalities. 22. Consult with Aboriginal prisoners and community members regarding improved support for grieving, especially for prisoners who cannot attend family events or funerals. 23. Develop appropriate facilities within prisons to support parenting, including parenting education and other practical programs that maintain parenting skills 24. Consult with Aboriginal women in the community and prisoners regarding advocacy for prison alternatives for women who may have to give birth in prison	8. Improve information sharing and support for offenders' families, so that they are better involved in reintegration preparation and planning. 2. Recognise prisoner diversity and tailor programs to be most responsive to particular groups, taking differences and specific needs into consideration. Programs must be appropriately tailored to women, Aboriginal, Culturally and Linguistically Diverse (CALD), and learning or cognitively impaired offenders; all of whom require customised responses.	169. That where it is found to be impossible to place a prisoner in the prison nearest to his or her family sympathetic consideration should be given to providing financial assistance to the family, to visit the prisoner from time to time 147. That police instructions should be amended to make it mandatory for police to immediately notify the relatives of a detainee who is regarded as being 'at risk', or who has been transferred to hospital
Flexible pathways		
25. Establish facilities in all prisons to support the use of telehealth and videoconferencing for Aboriginal prisoners to access specialist assessments, treatments and care and avoid unnecessary, costly and disruptive transfers. 26. Increase the number of in-reach programs, especially to form links with primary health and to provide therapeutic services for alcohol and other drug misuse mental illness, domestic and family violence and other trauma.	N/A	173. That initiatives directed to providing a more humane environment through introducing shared accommodation facilities for community living, and other means should be supported, and pursued in accordance with experience and subject to security requirements

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
Recovery, rehabilitation, therapeutic services		
27. Investigate, plan and implement a comprehensive therapeutic mental health care service within the SAPHS, using the New Zealand Model of Care as a reference point, ensuring cultural appropriateness for the Aboriginal prisoner population and including: a. Brief mental health interventions for people on short-term sentences and remand. b. Increased opportunities for mental health maintenance including meaningful activities and vocations. 28. Prepare and implement a comprehensive chronic and communicable disease strategy for primary and secondary prevention, ongoing self-management, evidence-based health support (including structured physical activity and nutritional dietary options) and high quality medical and allied health services for prisoners with heart disease, diabetes, respiratory conditions, kidney disease, communicable diseases and common mental illnesses. The three existing strategies/plans for diabetes, heart and stroke and cancer already developed and endorsed are key foundation documents for this purpose. 29. Prepare and implement disability support programs through the use of physiotherapists, occupational therapists and exercise physiologists and ensure daily care needs can be met for Aboriginal prisoners with day to day care needs.	7. Investigate the development of dedicated therapeutic communities within the prison environment. 6. Ensure drug and alcohol treatment programs are an integral part of DCS rehabilitation services. 16. Ensure DCS risk assessment tools and processes gather the information required to appropriately prioritise and target programs to the individual needs of offenders. 12. Investigate opportunities for social ventures.	151. That, wherever possible, Aboriginal prisoners or detainees requiring psychiatric assessment or treatment should be referred to a psychiatrist with knowledge and experience of Aboriginal persons. The Commission recognises that there are limited numbers of psychiatrists with such experience. The Commission notes that, in many instances, medical practitioners who are or have been employed by Aboriginal Health Services are not specialists in psychiatry, but have experience and knowledge which would benefit inmates requiring psychiatric assessment or care 171. That Corrective Services give recognition to the special kinship and family obligations of Aboriginal prisoners which extend beyond the immediate family and give favourable consideration to requests for permission to attend funeral services and burials and other occasions of very special family significance

APPENDIX 4
Recommendations and Royal Commission Into Aboriginal Deaths in Custody (cont.)

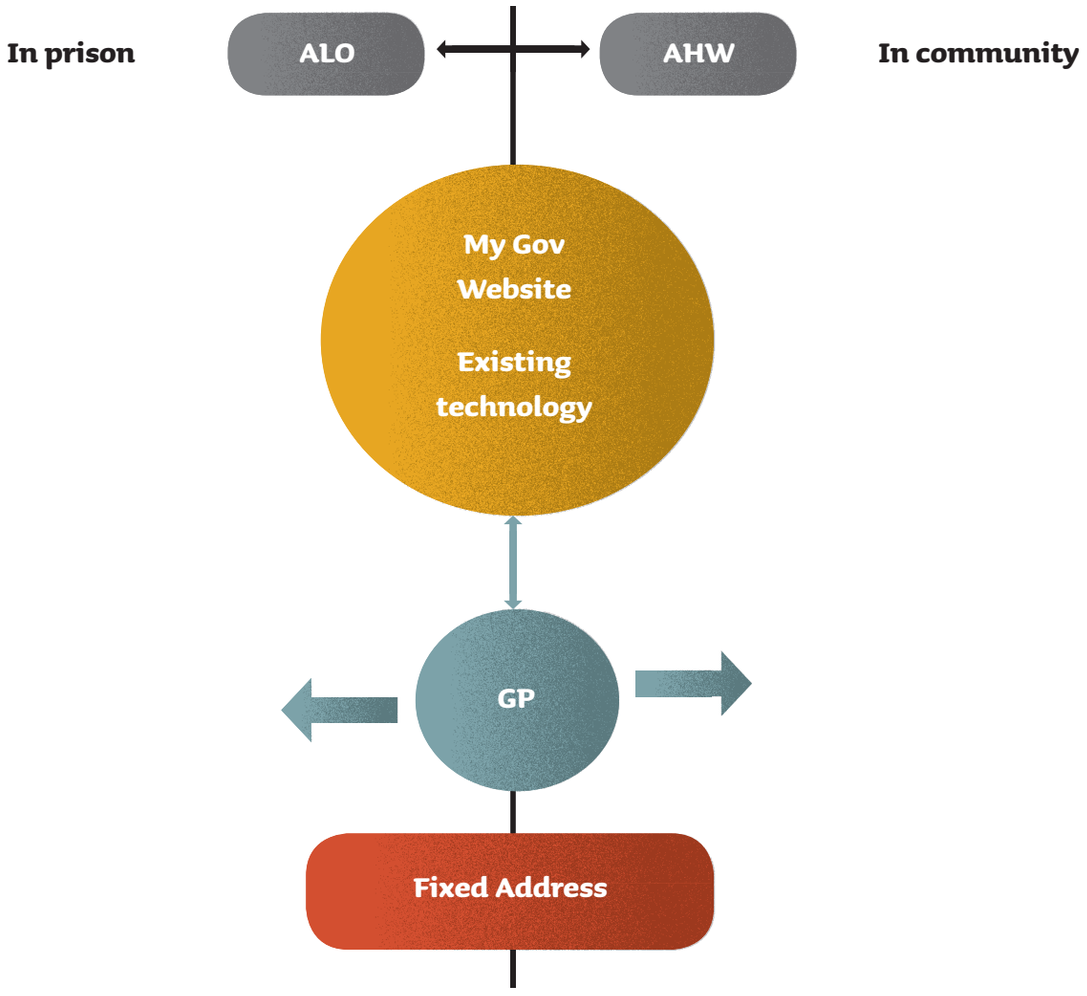
Prisoners linked to community based services pre-release

MODEL OF CARE FOR ABORIGINAL PRISONER HEALTH	DCS 10% BY 2020	ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY
30. Develop systems and procedures to ensure relevant medical records, medications and links to community services are prepared for all prisoners prior to court hearings to facilitate effective transition of health care and wellbeing if prisoners are released off-Court including development of a checklist to cover: a. Entitlements - Medicare number and card, Centrelink status b. Access to finances c. Access to medications, including contraception d. Contacts for primary health care and specialist support e. Housing f. Transport	9. South Australian Prison Health to enhance prisoners' access to health services and ensure the delivery of medical plans on release, for prisoners requiring ongoing medical interventions. 24. Ensure that Aboriginal offenders who are returning to Country receive specialised transition supports and services	157. That, as part of the assessment procedure outlined in Recommendation 156, efforts must be made by the Prison Medical Service to obtain a comprehensive medical history for the prisoner including medical records from a previous occasion of imprisonment, and where necessary, prior treatment records from hospitals and health services. In order to facilitate this process, procedures should be established to ensure that a prisoner's medical history files accompany the prisoner on transfer to other institutions and upon re-admission and that negotiations are undertaken between prison medical, hospital and health services to establish guidelines for the transfer of such information 172. That Aboriginal prisoners should be entitled to receive periodic visits from representatives of Aboriginal organisations, including Aboriginal Legal Services 266. That the linking or integrating of mental health services for Aboriginal people with local health and other support services be a feature of current and expanded Aboriginal mental health services

APPENDIX 5
Concept Map – Existing Technologies

This concept map describes how an existing information sharing platform, the MyGov website and related applications, can be used by healthcare professionals and other support services and networks both within the community and the prison system. The diagram below illustrates how an Aboriginal patient's regular General Practitioner (GP) in the community could be accessed by health staff within the prison system to inform prison health staff of that patient's known and documented health needs pre-incarceration and to support continuity of care upon release.

During the incarceration process, prison health and other support staff (e.g. Aboriginal Liaison Officers) can populate data highlighting episodes of care provided. The community GPs and Aboriginal Health Workers (AHWs) can then resume the patient's care and treatment regime post-release in a manner that is consistent with that which was delivered within the prison setting. This concept also highlights the importance of having a fixed address both pre- and post-release to ensure access to community based health care services.



APPENDIX 5
Concept Map – Existing Technologies (cont.)

Concept	Description
	*Concept* • Use an existing government website. • Specialist information can be entered into website. *Current barriers to overcome* • Prisoners are not eligible for Medicare. • Literacy and numeracy skills may be a barrier. • Internet use in prison by prisoners is limited.
	*Concept* • The ALO in prison can assist prisoners to populate health record on line if required. • The ALO in prison and another ALO post-release can coordinate health care across prison-community divide.
	*Concept* • General Practitioners can provide continuity of care pre-, during and post-prison. • The GP can access the MyGov Website health records, including in prison and specialist care.
	*Concept* • Prisoners would have a fixed address prior to induction and discharge so that they can access community based healthcare services including mental health and outpatients appointments, Centrelink and Medicare.

APPENDIX 6
Workshop Three Findings

Barriers

- Lack of communication between DCS and Health – will mean the model won't work
- MBS and cost – who pays for local services?
- Access for programs
- Funding model
- Percentage of beds in country e.g. 2/3
- Adequate remuneration for staff working in a big and hard role
- Limited resources and finance to assist with implementing the model
- Isolation (moved from their Country)
- Limited transport options available post release
- Culture – difficult to implement new process in prison system
- Responsibility – whose is it?
- Lack of communication between all prison services
- Not enough interpreters
- Barriers of the unknown: health language, cultural language
- Lack of trusting relationships within the system and between patients and staff
- Patient management – see value in some conversations around health, but may not provide whole story of health if they didn't see value
- Communication – patient health confidentiality
- Courts- released from court, difficult to complete discharge planning and inform family
- Access – security processes preventing health care, lock down
- Country Health unwilling to provide services to prisoners
- Medicare Federals vs State: PBS, Medical appointments
- Resources including Aboriginal workers and integrated agencies
- Homelessness plus housing issues – no fixed address limits access to services post-release
- Very limited information in programs passed onto SAPHS
- No Birthing centres in women's prison

APPENDIX 6
Workshop Three Findings (cont.)

Facilitators

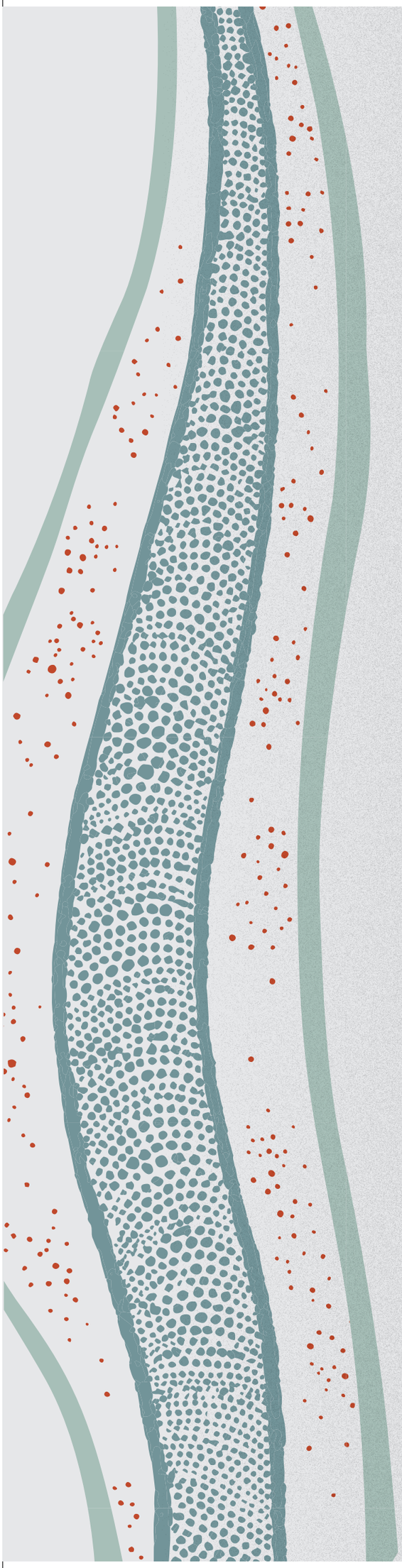
- Aboriginal Elder – increase visits to once per week per site at a minimum (presently one visit per month, per prison)
- Increase budget for prisoner access to Elders
- Employment of Aboriginal Health Workforce
- Establish supportive structure for staff on ground through to Leadership
- Supporting people in prison to access Mental Health Care Plan
- Resources to assist communication across culture and health
- Workshop specific needs of APY and other remote prisoners
- Prisoners on AOD, mental health and cognition issues need lots of support – not self-care models
- Shared care responsibilities DCS /Health /Family/ Patient
- Model based on equity vs equality
- Can be linked with Nurse-led Portfolio Clinics
- Equal partners – DCS and SAPHS have shared responsibility for implementation
- Adaptable to each site and specific needs
- More funding for Health Services to provide further support

Immediate implementation (e.g. within 6 months)

- Address cost shifting between departments – false economy
- Shared vision for future – DCS/ SAPHS
- Map out role description, tasks of Aboriginal Health Practitioner
- Communication and linkages DCS and SAPHS
- Information platform detailing services available post-release
- Employ Aboriginal Health Practitioners in all prison sites
- Paper based my Health Care plan
- Aboriginal Health Worker plan in place with Mental Health Care Plan
- Aboriginal Health Practitioner to assist with throughcare planning
- Opportunities to open up communication with DCS and Health
- Access audio/ visual technology to create links to services
    - Explore free services through Skype
    - Commence Elders visiting program
    - Healing circles or yarning circle
    - Gender preference
    - Re-implement DCS questionnaires regarding cultural links and identity of Aboriginal prisoners (last used 2008)
    - Funding commitments for resources
    - New RAH could make themselves more available for videoconferencing across more clinics
    - Equivalent Allied Health services in-reach at all sites metro and country prisons
    - DCS run courses on resilience for patients
    - Medicare chronic disease pathways
    - More Mental Health/ Diabetes/ Cardiac link nurse clinics
    - Integrated case management across issues with open communication and agreed deliverables
    - More drug and alcohol counselling and communication between DCS/ SAPHS
    - Access to mental health history (through SAPHS) prior to starting DCS programs

APPENDIX 7
Description of SA Prisons

Adelaide Women's Prison	The Adelaide Women's prison is located on Grand Junction Road, Northfield and shares the location with the Adelaide Pre-release centre that can hold approximately 176 prisoners. The Adelaide Women's Prison is an induction and release site, at time of the consultation. The total prison population was 168 prisoners with a mix of high, medium and low security ratings. Approximately 30% of the prison population are Aboriginal people.
Adelaide Pre-release Centre	Capacity is 104 (80 male, 24 female).
Adelaide Remand centre	The Adelaide Remand Centre is located on Currie Street, Adelaide. The Remand Centre is an induction site and provides access to a 24 hour health centre. At time of the consult, the total prison population was 274 prisoners, a mix of both Remanded and sentenced prisoners, approximately 15-20% of the prison population are Aboriginal people.
Yatala Labour Prison	Yatala Labour Prison is located on Grand Junction Road, Northfield. Yatala is Adelaide's largest prison and is an induction site. At time of consult, the prison population was 590 prisoners, approximately 125 Aboriginal prisoners; its capacity is 576. A mix of maximum, high and medium security ratings. Yatala Labour prison also acts as a transition site for prisoners being transferred to Adelaide from other prison locations to access health care services. Approximately 60% of the prison population at Yatala Labour Prison is on remand.
Mobilong Prison	Mobilong prison is located at Maurice Road, Murray Bridge. At time of consult, the prison population was 472 prisoners, approximately 100 Aboriginal prisoners with a mix of medium and low security ratings. Approximately 50% of the prison population at Mobilong Prison is on remand. The Mobilong prison health team has 12 Registered Nurses, 3 Enrolled Nurses, 4 casual Registered Nurses and 1 Medical officer.
Port Augusta Prison	Port Augusta Prison is located at Highway 1, Stirling North. Port Augusta Prison is the state's largest regional prison and has the facilities to hold both male and female prisoners on site. At time of consult, the prison population was 525 prisoners, 217 Aboriginal prisoners and 25 women. The prison has a mix of high, medium and low security ratings, a prison industries, a pre-release work program including off site remote work camps, a dedicated specific traditional Aboriginal Accommodation Unit, a special needs unit, a protectee unit and holds both Aboriginal and non-Aboriginal Women. Port Augusta Prison holds a mix of senior experienced Registered Nurses/Enrolled Nurses and Junior, recently graduated Registered Nurses. The prison health team has 16 permanent staff and 2 casual staff.
Port Lincoln Prison	Port Lincoln Prison is located at 1 pound lane, Port Lincoln. Port Lincoln Prison is a 202 bed facility with a mix of medium and low security ratings. At time of consult approximately 25% of the prison population are Aboriginal people.
Cadell Training Centre	Cadell Training centre is located at Boden Road, at time of consult. Cadell Training Centre's population was 210 low security prisoners, approximately 20-30 Aboriginal people. Cadell Training Centre is a release site, the prison site is located on 1600 hectares and considered to be a working farm. Prisoners at Cadell Training Centre participate in employment and educational programs to assist with post release planning.
Mt. Gambier Prison	Mount Gambier Prison is located at Benara Road, Moorak and is the only privately managed prison in the state. The Prison is managed by G4S custodial services and the contract in monitored by the Department of Corrections. Mount Gambier Prison has a capacity of 493 people.

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