

Holistic primary health care for Aboriginal and Torres Strait Islander prisoners: exploring the role of Aboriginal Community Controlled Health Organisations

Simon Pettit,¹ Paul Simpson,¹ Jocelyn Jones,² Megan Williams,³ M. Mofizul Islam,⁴ Anne Parkinson,⁵ Bianca Calabria,⁵ Tony Butler¹

The offender population is one of the most stigmatised and socially excluded groups in society. Epidemiological studies of prisoners consistently find high levels of physical ill health, psychiatric illness and communicable diseases, and engagement in health risk behaviours such as smoking, alcohol consumption, illicit drug use and violence.^{1,2} For Aboriginal and Torres Strait Islander (hereon 'Indigenous') offenders, disadvantage is further compounded by poor social determinants of health. Since colonisation more than 230 years ago, Indigenous Australians have lower levels of political representation, educational attainment and income when compared to the general Australian population, as well as higher rates of social exclusion, unemployment, trauma and ill-health, and shorter life expectancy.³ Indigenous Australians frequently experience racism and low levels of access in mainstream health services and the legal system.^{4,5} These issues underscore the importance of community controlled primary health care for Indigenous offenders that is contextually relevant, holistic and culturally safe.

Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) provide culturally appropriate, autonomous primary health care services that are initiated, planned and governed by local Aboriginal Australian communities through an elected board of directors.⁶

Abstract

Objective: Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) have been identified as having an important role in improving the health and wellbeing of individuals in prison; however, a lack of information exists on how to strengthen this role. This paper explores the experiences of ACCHO staff in primary health care to individuals inside or leaving prison.

Methods: Nineteen staff from four ACCHOs were interviewed. ACCHO selection was informed by proximity to prisons, town size and/or Local Government Area offending rates. Thematic analysis of the interviews was undertaken.

Results: While most ACCHOs had delivered post-release programs, primary health care delivery to prisoners was limited. Three themes emerged: i) a lack of access to prisoners; ii) limited funding to provide services to prisoners; and iii) the need for a team approach to primary health care delivery.

Conclusion: A holistic model of care underpinned by a reliable funding model (including access to certain Medicare items) and consistent access to prisoners could strengthen ACCHOs' role in primary health care delivery to people inside or leaving prison.

Implications for public health: ACCHOs have an important role to play in the delivery of primary health care to prisoners. Existing models of care for prisoners should be examined to explore how this can occur.

Key words: Indigenous, prisoners, health care, Aboriginal and Torres Strait Islander Community Controlled Health Organisations, Aboriginal Medical Services.

ACCHOs are represented nationally by the National Aboriginal Community Controlled Organisation (NACCHO), which engages directly with policy makers and funding bodies, links ACCHOs to facilitate health service delivery and research, advises on research, and provides leadership on service delivery principles such as community control. Community control is vital for culturally appropriate and acceptable health

care services in Indigenous communities and enacts articles of the United Nations Declaration on the Rights of Indigenous Peoples, ensuring self-reliance, self-determination, appropriate and acceptable health care.⁶

Since the establishment of the first ACCHO in inner Sydney in 1971, the network of ACCHOs has grown to 143 across Australia, providing more than three million episodes

1. The Kirby Institute, University of New South Wales

2. Faculty of Health and Medical Sciences, The University of Western Australia

3. Graduate School of Health, University of Technology Sydney, New South Wales

4. Department of Public Health, La Trobe University, Victoria

5. Research School of Population Health, Australian National University, Australian Capital Territory

Correspondence to: Dr Paul Simpson, The Kirby Institute, University of New South Wales, Wallace Wurth Building, Sydney, NSW 2015; e-mail: psimpson@kirby.unsw.edu.au

Submitted: May 2019; Revisions requested: August 2019; Accepted: August 2019

The authors have stated they have no conflict of interest.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

Aust NZ J Public Health. 2019; 43:538-43; doi: 10.1111/1753-6405.12941

of care each year for approximately 350,000 people.⁷ Primary health care services provided by ACCHOs embody the Aboriginal definition of health, which is not just about an individual's physical wellbeing but also the social, emotional and cultural wellbeing of the community, and takes a whole-of-life perspective that incorporates a cyclical concept of life–death–life.⁸ ACCHOs provide comprehensive primary health care that includes health education, health promotion, social and emotional wellbeing support and a range of other community development initiatives.⁹

Limited access to primary health care services for Indigenous peoples is a major barrier to addressing the overall aim of the Australian Government's 'Closing the Gap' framework.¹⁰ Data show that, compared to mainstream services, ACCHOs are frequently accessed by Indigenous people.¹¹ A 9% growth in Indigenous community members accessing their local ACCHO was observed between 2012–13 and 2014–15, with a 23% increase in the total number of episodes of care during this time.⁷ In a study comparing outcomes and indicators between ACCHOs and mainstream services, ACCHOs performed better in terms of best practice care, monitoring clinical performance, increasing engagement of Indigenous community members, and better leadership in training non-Indigenous staff in Indigenous health matters.¹²

Barriers to accessing mainstream services extend also to Indigenous Australians in the criminal justice system. In Australia, Indigenous people comprise 28% of the prisoner population, but only 2% of the general population.¹³ Australian state and territory legislation states that prisoners must be able to access health care when they require it, and that they have the right to the same level of care as in the wider community¹⁴ – a right referred to in the international context as the 'equivalence of care' principle.¹⁵

Incarceration causes a person to be separated from their community.¹⁷ A recommendation (168) by the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) requires that a person be incarcerated as close to their home community as possible.¹⁶ Incarceration can also disrupt continuity of holistic health care provided by an ACCHO,¹⁷ if that ACCHO has no means of accessing the prisoner. Other custodial health and safety recommendations made by the RCIADIC state

that Corrective Services departments should review the provision of health services to Indigenous prisoners including the *level of involvement* of ACCHOs (Recommendation 152c) and the *exchange* of relevant health information between prison medical staff and ACCHOs (Recommendation 152e).¹⁶

Australia's National Indigenous Drug and Alcohol Committee (NIDAC) asserts that improvements in health services for Indigenous prisoners and juvenile detainees may assist in reducing the overall prisoner numbers.¹⁸ Areas noted for improvement included health screening on reception, increasing uptake of recommended treatments, and enhancing prisoner throughcare by facilitating access of Indigenous health and other services to Indigenous prisoners.¹⁸ NIDAC highlighted that "the provision of a 'one health service fits all' model, as in the case for many corrections systems, creates a disjointed and unsuitable approach" for addressing health needs of Indigenous prisoners.¹⁸ In response, NIDAC recommended several strategies for involving ACCHOs to improve the health care of prisoners and their ongoing care post-release.¹⁸ However, there is a dearth of literature on external health care provision to Australia's prisoners from which to plan coordinated actions and resource allocation. Only a small number of reports are available on health care provided by community-based organisations in prisons.^{19,20}

Health care varies greatly in Australia's state- and territory-based prisons, with government Departments of Health providing health care services to some through agencies such as the Justice and Forensic Mental Health Network in New South Wales (NSW), and Departments of Justice or contracted private companies providing services to others.²¹ There is no nationally coordinated approach or body whose role it is to monitor prisoners' health care needs, and no national strategy for assessing or meeting the specific health needs of Indigenous prisoners.²² Australia's publicly funded universal health care system – the Medicare Benefits Scheme and Pharmaceutical Benefits Scheme, collectively known as Medicare – is suspended for prisoners during incarceration. This is because other state- and territory-level government departments become responsible for providing health care to prisoners.²³ However, this arrangement has been identified as problematic, with concerns that it reduces resources or opportunities for providing

comprehensive health care to prisoners that is equivalent to that available in the community.²³

This project was designed by a team of Aboriginal and non-Aboriginal researchers working at the nexus of the justice and health systems, and with specialisations in Indigenous health research, epidemiology, qualitative research and health services research and evaluation. Three of the team members identified as Indigenous Australians. The primary aim of the research was to explore prisoner health services and programs provided by a selection of ACCHOs, including the challenges and enablers of delivering these, and implications for further research.

Method

ACCHO sites were selected based on geographical proximity to prisons, town size and population. Four sites were identified across three jurisdictions after considering existing geo-spatial data on prison and ACCHO locations and offending rates. Two ACCHOs in NSW from Local Government Areas (LGAs) with higher offending levels, a low socioeconomic status index, and a prison were selected; and two ACCHOs near a prison from other jurisdictions were selected for comparative reasons. Sampling of participants was purposive and designed to reflect the breadth of roles performed within ACCHOs, including management, clinicians, social workers and administrative staff. Fifteen semi-structured interview questions were devised by the team. In total, 19 interviews were conducted by two Indigenous interviewers. Interviews were audio-recorded and then transcribed.

Latent thematic analysis was conducted using a six-phase protocol: i) familiarisation with the data; ii) generating initial codes from the data; iii) searching for themes; iv) reviewing themes; v) defining and naming final themes; and vi) writing up findings for dissemination.²⁴ Two research team members (Petit and Simpson) independently conducted phases one to four on eight interviews and met to discuss their findings and to complete phases five and six. After achieving a consensus on emerging themes and sub-themes, one team member (Petit) conducted all the six phases of analysis for the remaining interviews. To maintain confidentiality, each participant was assigned a pseudonym when reporting on the findings.

Results

Three core themes were identified from the interviews: i) a lack of access to prisoners; ii) limited funding to deliver services in prison; and iii) the potential for involvement in a team approach to primary health care delivery for prisoners. These themes resonated among all four participating ACCHOs. Although there were few differences between reported experiences among ACCHOs, one ACCHO stood out in terms of its higher level of engagement with its local prison compared to other ACCHOs. All but one of the participating ACCHOs were located within 10 kms of a prison. The one ACCHO that was located 50 kms from the nearest prison reported less engagement with the prison compared to other participating ACCHOs.

Lack of access to prisoners

The theme 'lack of access to prisoners' represents a number of facets relating to the difficulties ACCHOs experienced in physically accessing prisoners to provide health care. Some participants spoke of previous formal partnerships and programs with local prisons over an extended period of time.

While all participants expressed a desire to expand and improve their ACCHO services to prisoners, most told of limited and episodic access to prisoners that were largely outside of a primary health care scope. One interviewee, Kate, an executive manager, reflected that "there were some talks but it's like the usual response is 'It's covered by Justice Health'. We have had some; a partnership with them ... but as far as primary health care goes, no". Kate reported that there had been more contact "in the earlier days ... they actually used to have the nurse and one of the clinicians go" (to the local prison), but not since "changes of government policies". Other than that, Kate said, "We've had prisoners access [the ACCHO] for a procedure or something where they've been escorted" (by guards) – but not for any strategic access to their primary health care services.

Some participants described having greater success providing non-clinical programs in prison such as smoking cessation clinics and cultural workshops as well as parental support programs, and mental health and wellbeing promotion. These programs occurred through preparing required documentation and devising procedures

to adhere with prison requirements. This took some time, as ACCHO mental health coordinator Amanda explained, "I met with them a month ago. We're in that process of getting everyone's ID through, waiting on getting approval for everyone to have that clearance to be able to go in there".

When looking at what enabled access, many participants spoke of the importance of established relationships in the past between individual ACCHO staff and prison decision-makers. Yet, it takes time to develop relationships with prison staff who can facilitate access to Indigenous prisoners. When talking about the present time, most participants spoke of less-developed relationships. Fiona, a senior finance officer at an ACCHO, explained, "I'm aware that we have done like an outreach kind of 'go and visit the prisons' to kind of have a bit of a relationship. And we probably have only done that maybe twice that I know of in the past two years". For ACCHOs, like other fee-for-service clinics, 'time is money' and developing relationships that have few precedents of success can be difficult to rationalise.

However, even when relationships or partnerships were established, at times these were unreliable. If the prison staff member was unavailable, if the prison was 'locked down' (when prisoners are confined to their cells for what is usually a disciplinary or security measure), or a staff member did not respect the value of ACCHO staff, access was denied or slowed down. One interviewee, Sue, a chief executive officer, said that racism had contributed to restricted access to prisoners for the provision of health care:

... it'd depend on who was on, the relationship that that person [prison staff] had with our doctor, how quickly they'd move through [the prison security and cell blocks]. And that's the risk when you provide a health service in a prison; if somebody doesn't like you or there's racism and stuff like that, they can be as slow as they like where you might see one or two. But then, if you got a good one, they can move them through. – Sue, CEO

The key implication of slow movement through prison security and cell blocks is less time to potentially spend with Indigenous prisoners.

One service did, however, describe sustained access to prisoners. This occurred through a specially funded program to enable the ACCHO to do so. That is, the ACCHO did not have to rely on their existing funding from

which to deliver services to prisoners, but were able to develop a particular strategy:

We piloted the program through the Commonwealth back then [12–16 years ago] for a doctor and an Aboriginal health worker to go to [prison]. We went there for 10 years and when we did get in there, they just couldn't get enough of us. – Sue, CEO

The latter part of this quote highlights a related issue to access to prisoners for the specific ACCHO: the lack of opportunity to grow services to meet demand.

Alongside the challenges of accessing prisoners were the difficulties of accessing recently released prisoners, due to individuals leaving the local area to return home:

One of the issues that we had with that program was follow-ups for prisoners became quite challenging because many of the prisoners that they were working with came from different areas. And so, when they were released, they went back to their areas, and then it was quite difficult to keep in contact with them. – Jennifer, CEO

Throughcare programs, designed to support a prisoner and prepare them for release and post-release, have often been described as under-developed and not meeting needs of prisoners.^{20,25-30} ACCHOs have been identified as providing models of care that generally reflect throughcare, including capacity to provide intensive care, coordinated among the required multi-disciplinary teams and over sustained periods of time.²⁷

Limited funding

Funding for ACCHOs is generally obtained from a variety of sources. In the past, cessation of funding, or under-funding, meant that programs for prisoners and those exiting prison would be stopped or not be given enough time to develop and succeed.²⁷ Some participants spoke of staff funding issues and how ACCHOs must remain competitive and attractive to staff to maintain good quality of care:

... we have to be competitive, with professionals that warrant a certain salary because of their training in Aboriginal health and you need to be funding that. – Alex, clinical director

In describing funding models to provide health care to people in prison, Medicare was reflected on by some participants:

See, Justice Health provides services while they're in prison, and post-release it's the general community AMS [ACCHO]

hospital, but also prisoners can access, under emergency, the hospitals as well. We don't have any access to the prison but one of the biggest barriers we have is that there's no funding for inmates to access [ACCHO] whilst in prison. But they're not entitled to access Medicare either. – Kate, executive manager

However, only three participants indicated they were aware that individual Medicare benefits were suspended upon incarceration, such as Steve, a general practitioner who said, "I didn't know they lost their Medicare card when they went to gaol".

Participants who were aware of the Medicare suspension had great insight into the grey area that Indigenous prisoner health occupies and the inability to receive the targeted care that individuals would enjoy outside of prison:

It impacts on from GPs and nurses the ability to be able to generate this Medicare income that can assist in getting services for them. So, getting out to have specialist appointments, having X-rays or, you know, having those other things that cost a lot of money, whether the prison will allow that to happen or not. So, I think it impacts on the decisions that are made within the prison system. – Jennifer, CEO

Further, there is the risk of prison visits affecting the services ACCHOs are funded to undertake:

Part of your incarceration is you lose your entitlement to Medicare. So, from an AMS [ACCHO] point of view, if we were to go and provide Aboriginal health checks and those things, there's no funding to do so. So, we're actually taking away services that we're funded for from our community to go and deliver services that we couldn't claim a 715 [Medicare Health Assessment for Aboriginal and Torres Strait Islander People] for. The only way around that is to provide funding for it [from Medicare]. – Kate, executive manager

Upon becoming aware of prisoner's Medicare suspension, there was overall acknowledgement by participants of the potential benefit of a Medicare-funded model in delivering primary health care to Indigenous people in prison. All participants were confident that an adequately funded team, possibly through certain Medicare items that are separate and in addition to their existing allowance, could deliver excellent patient outcomes to Indigenous people in prison.

Potential team approach to primary health care delivery

Interviews explored the potential role of ACCHOs in Indigenous offender health ranging from establishing best practice indicators for successful health care delivery and the need to develop models of care that included post-prison release holistic care.

In discussing beneficial features of a primary health care model specific to prisoners and those leaving prison, most participants emphasised the need for a multi-disciplinary team-based approach consisting of a clinician, social/Aboriginal health worker, mental health worker and prison-based Aboriginal wellbeing officer. Most also had specific views on post-release care. For example, Steve discussed the idea of a liaison officer and a social and wellbeing team:

I think having an Aboriginal liaison officer or social and emotional wellbeing people ... team ... involved when they get released from the gaol, I think it works well. So, they can probably find their way to seeing a doctor and all, or a clinician, or a nurse over here. So, having that team involved early, after the incarceration is finished, I think is a good idea. – Steve, general practitioner

Similarly, Jennifer spoke of a team-based approach or 'wrap-around' service, referring to a system-of-care model of health care delivery:³¹

... we should have a dedicated prison-release program because that way you're capturing those prisoners that need to be [seen]. Like I said, having that 'wrap-around', primary health care, assessments, the mental health, you know, the other things we can deliver that can all be tailored and factored into a program, a prison release program if we've got that. – Jennifer, CEO

Some participants spoke of continuity of care being difficult to achieve. They explained how drug treatment regimens and ongoing treatment plans can become disconnected between the community and prison systems. Several spoke of how a lack of communication and transferring of clinical information creates problems between prison health care and the external ACCHO model. Amanda, in the mental health context, explained:

Yeah, for us the biggest problem is getting that information. We often don't know if they have a mental condition. We don't know what medication they're on. We

don't understand their programs, what they're needing. – Amanda, mental health coordinator

For Jan, a social worker, the breakdown in communication meant being limited in what services could be provided:

... the information we will basically get is they're leaving. We don't know their journey. We don't know their ... And we might know the reason they went to gaol, but we don't know the ... kind of ... what transpired for them. We don't know what they're wanting, what they're looking for. – Jan, social worker

In some circumstances, ACCHOs are the 'first port of call' for people when released from prison. However, the ACCHO will generally have no awareness of the individual's prison release and pending visit, so no planning takes place. As Bruce, a social-health team manager, explains in relation to one ACCHO service user:

He was there [in prison] for 17 years; a lot has changed. He couldn't read or write, so they gave him a bus ticket to leave the gaol. He didn't know how to catch a bus. Another had a prisoner turn up to the site still in his prison greens ... we have quite a few that still turn up in their prison greens. – Bruce, social-health team manager

Such a disconnection of communication between ACCHOs and prison-based health services and prison managers is likely to impact the level of care that can be provided upon release.

Discussion

This research aimed to understand current and previous Indigenous offender health services and programs offered by four ACCHOs and the experiences, challenges and enablers of delivering these. While ACCHOs provide culturally appropriate and effective services to significant numbers of Indigenous citizens in the community, findings showed that there were several barriers to achieving this for Indigenous people in prison, including limited access and funding models.

Overall, ACCHO staff spoke of being unable to physically access prisoners due to security protocols and the attitudes of individual facility decision-makers. Although an existing relationship between individual ACCHO staff and prison decision-makers had been an important enabler to access Indigenous prisoners for some ACCHOs, it also could

make access vulnerable to individual differences within prison staff. Accessing people after release from prison was also raised by many, with care planning and follow-up difficulties specifically noted.

Although health programs and services for people in prison had been implemented by the ACCHOs, including nurse and clinician in-reach services, health promotion clinics and cultural wellbeing workshops, for most, these programs/services have not been sustainable due to limited funding. Reforming health service funding arrangements for Indigenous prisoners is a feasible way to enhance the contribution of ACCHOs to Indigenous health. One possibility is for certain aspects of the ACCHOs' work with prisons to be funded under Medicare arrangements, as they are for other primary health care services. Under the *Health Insurance Act (1973)* the Federal Health Minister has the capacity to grant an exemption to the Act that would allow Medicare rebates to be claimed for services in a prison setting.^{23,32} It has been suggested that the Health Assessment for Aboriginal and Torres Strait Islander People (MBS item 715) could be claimed under such an exemption.²³ In addition to granting exemptions, a cost-sharing scheme is also worth exploring, where Australian State and Commonwealth Governments formulate a funding model that allows ACCHOs access to imprisoned clients.²³

Unsurprisingly, most ACCHO staff recognised a need to develop models of care in the offender health space – a model that includes a holistic primary health team approach and a focus on continuity of care planning. Such findings resonate with elements of models of care for Indigenous prisoner health developed in the ACT³³ and South Australia (SA).³⁴ The ACT model of care was developed in 2007 and led by Winnunga Nimmityjah Aboriginal Health Service in response to the construction of the ACT's first prison, which was completed in 2008. The SA model was developed in 2017 by the South Australian Health and Medical Research Institute (SAHMRI) for SA Prison Health Services and Department of Corrective Services. In the SA model, ACCHOs, together with Local Health Networks (SA Department of Health), are noted as instrumental in the implementation of prison in-reach programs. Although these models have different emphasis on the roles of ACCHOs, both models present important elements required of a holistic model of care for Indigenous prisoners such as pre-release planning, culture, spiritual

identity, communication, access and family. However, the present project identifies key implementation enablers such as a sustainable funding model, and consistent and reasonable access to prisoners. Further research is required to better understand the feasibility of ACCHOs delivering primary health care within prisons taking all of the above into account.

This qualitative study provides key insights about opportunities for improving integration between prison health services and ACCHOs. The project was limited to three out of seven Australian jurisdictions and, while geo-spatial mapping was used to select participating services, as well as data about prison populations and locations, it does not represent the experiences and needs of all ACCHOs.

Conclusion

Findings showed that while most participant ACCHOs had delivered services to people in the community upon release from prison, opportunities to deliver primary health care services to individuals in prisons were very limited. Two key barriers to implementing holistic and culturally appropriate health care in prisons were lack of access to prisoners due to security protocols and prison staff attitudes, and lack of a sustainable funding model. A reliable funding model underpinned by consistent access to prisoners and access to certain Medicare items could resolve this conundrum, as has been previously proposed.²³ To this end, we encourage the Commonwealth of Australia to engage in appropriate discussions to resolve this matter. Additionally, custodial and prison health providers need to engage in meaningful discussions with ACCHOs to address prisoner access issues.

Acknowledgements

We would like to acknowledge ACCHO staff and participants who gave their support and time. We also acknowledge Dr Jill Guthrie and other Indigenous Offender Health Capacity Group members for their guidance and support of the project. This research is funded by an Australian National Health and Medical Research Council grant (APPA1057492), as part of the Australian Centre for Research Excellence in Offender Health; and Seed funding from the Research School of Population Health, Australian National University.

References

- Butler T, Andrews G, Allnutt S, Sakashita C, Smith NE, Basson J. Mental disorders in Australian prisoners: A comparison with a community sample. *Aust N Z J Psychiatry*. 2006;40(3):272-6.
- Indig D, Topp L, Ross B, Mamoon H, Border B, Kumar S, et al. *New South Wales Inmate Health Survey: Key Findings Report*. Sydney (AUST): New South Wales Justice Health; 2010.
- Grace J, Krom I, Maling C, Butler T, Midford R, Simpson P. Review of Indigenous offender health (updated). *Aust Indigenous HealthInfoNet*. 2013;12:1-24.
- Kelagher M, Ferdinand A, Paradies Y. Experiencing racism in health care: The mental health impacts for Victorian Aboriginal communities. *Med J Aust*. 2014;201(1):44-7.
- Human Rights and Equal Opportunities Commission. *Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*. Canberra (AUST): Government of Australia; 1997.
- Bell KC, Daniels J, Hunter P, Mayers N, Murray R. Aboriginal community controlled health services. In: Commonwealth Department of Health and Aged Care, editor. *General Practice in Australia*. Canberra (AUST): Government of Australia; 2000. p. 74-104.
- Australian Institute of Health and Welfare. *Healthy Futures—Aboriginal Community Controlled Health Services: Report Card*. Catalogue No.: IHW 171. Canberra (AUST): Australian Institute of Health and Welfare; 2016.
- National Aboriginal Health Strategy Working Party. *National Aboriginal Health Strategy*. Canberra (AUST): AGPS; 1989.
- Hayman N, White N, Spurling G. Improving Indigenous patients' access to mainstream health services: The Inala experience. *Med J Aust*. 2009;190(10):604-6.
- Couzos S, Thiele D. The International Covenant on Economic, Social and Cultural Rights and the Right to Health: Is Australia meeting its obligations to Aboriginal peoples. *Med J Aust*. 2007;10(186):522-4.
- Gomersall JS, Gibson O, Dwyer J, O'Donnell K, Stephenson M, Carter D, et al. What Indigenous Australian clients value about primary health care: A systematic review of qualitative evidence. *Aust N Z J Public Health*. 2017;41(4):417-23.
- Panaretto K, Wenitong M, Button S, Ring I. Aboriginal community controlled Health services: Leading the way in primary care. *Med J Aust*. 2014;200(11):649-52.
- Australian Bureau of Statistics. *4517.0 - Prisoners in Australia, 2018*. Canberra (AUST): ABS; 2018.
- Corrective Services Act 2006 (QLD) [Internet]. 30 May 2017 [cited 2019 May 23]. Available from: <https://www.legislation.qld.gov.au/view/pdf/inforce/2017-05-30/act-2006-029>
- United Nations. *A/RES/37/194 - Principle of Medical Ethics*. Geneva (CHE): UN; 1982.
- Royal Commission into Aboriginal Deaths in Custody. *Royal Commission into Aboriginal Deaths in Custody: National Reports (Vol 1-5), and Regional Reports*. Canberra (AUST): AGPS; 1991.
- Levy M. Prisoner health care provision: Reflections from Australia. *Int J Prison Health*. 2005;1(1):65-73.
- National Indigenous Drug and Alcohol Committee. *Bridges and Barriers: Addressing Indigenous Incarceration and Health*. Canberra (AUST): Australian National Council on Drugs; 2009.
- Poroch N, Boyd K, Tongs J, Sharp P, Longford E, Keed S. *We're Struggling In Here!: The Phase 2 Study Into the Needs of Aboriginal and Torres Strait Islander People in the ACT Alexander Maconochie Centre and the Needs of their Families*. Canberra (AUST): Winnunga Nimmityjah Aboriginal Health Service; 2011.
- Poroch N. *You Do The Crime, You Do The Time*. Canberra (AUST): Winnunga Nimmityjah Aboriginal Health Service; 2007.
- Simpson PL, Guthrie J, Butler T. Prison health service directors' views on research priorities and organizational issues in conducting research in prison: Outcomes of a national deliberative roundtable. *Int J Prison Health*. 2017;13(2):113-23.
- Couzos S, Murray R. *Aboriginal Primary Health Care: An Evidence-based Approach*. Melbourne (AUST): Oxford University Press; 2008.

23. Plueckhahn T, Kinner S, Sutherland G, Butler T. Are some more equal than others? Challenging the basis for prisoners' exclusion from Medicare. *Med J Aust.* 2015;203(9):359-61.
24. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;3(2):77-101.
25. Borzycki M. *Interventions for Prisoners Returning to the Community.* Canberra (AUST): Australian Institute of Criminology; 2005.
26. Conroy E, Williams M. *Homelessness at Transition: An Evidence Check Rapid Review.* Sydney (AUST): Sax Institute for the NSW Family and Community Services and Family and Community Services Analysis and Research; 2017.
27. Haswell M, Williams M, Bignault I, Grande M, Jackson Pulver L. *Returning Home, Back to Community from Custodial Care: Learnings from the First Year Pilot Project Evaluation of Three Sites around Australia.* Canberra (AUST): Government of Australia; 2014.
28. Maruna S, Immarigeon R. *After Crime and Punishment: Pathways to Ex-Offender Reintegration.* Devon (UK): Willan Books; 2004.
29. Ross S. Bridging the gap between prison and the community: Post-release support and supervision. In: O'Toole S, Eyland S, editor. *Corrections Criminology.* Leichhardt (AUST): Hawkins Press; 2005. p. 169-82.
30. Willis M, Moore J. *Reintegration of Indigenous Prisoners.* Canberra (AUST): Australian Institute of Criminology; 2008.
31. Winters NC, Metz WP. The wraparound approach in systems of care. *Psychiatr Clin North Am.* 2009;32(1):135-51.
32. Health Insurance Act 1973 (Cth) [Internet] No. 42, 1974 Compilation No. 108, 1 July 2018 [cited 2019 May 23]. Available from: <https://www.legislation.gov.au/Details/C2018C00319>
33. Tongs J, Chatfield H, Arabena K. *The Winnunga Nimmityjah Aboriginal Health Service Holistic Health Care for Prison Model.* *Aborig Isl Health Work J.* 2007;31(6):6-8.
34. Sivak L, Cantley L, Kelly J, Reilly R, Hawke K, Mott K, et al. *Model of Care for Aboriginal Prisoner Health and Wellbeing for South Australia – Final Report.* Adelaide (AUST): Wardliparingga Aboriginal Health Research Unit; 2017.