

**WINNUNGA NIMMITYJAH ABORIGINAL
HEALTH SERVICE**



YOU DO THE CRIME , YOU DO THE TIME
BEST PRACTICE MODEL OF HOLISTIC HEALTH SERVICE
DELIVERY FOR ABORIGINAL AND TORRES STRAIT
ISLANDER INMATES OF THE ACT PRISON

June 2007

Nerelle Poroch
with support from

Julie Tongs, Peter Sharp, Mick Dodson, Steve Larkin, Katja Mikhailovich, Jodie Fisher, Ray Lovett, Kerry Arabena, John Van den Dungen, Jilpia Nappaljari Jones, Leila Smith, Jo Victoria, and Graham Henderson.



Note: The terms 'Aboriginal' and 'Indigenous' refer to the many different peoples and language groups who were living in Australia at the time of European settlement, including the Aboriginal peoples of the continent and the Torres Strait Islander people. This study's use of the term 'Aboriginal' also includes the Torres Strait Islander people.

WINNUNGA NIMMITYJAH ABORIGINAL HEALTH SERVICE

YOU DO THE CRIME, YOU DO THE TIME



*BEST PRACTICE MODEL OF HOLISTIC HEALTH SERVICE DELIVERY
FOR ABORIGINAL AND TORRES STRAIT ISLANDER INMATES OF THE
ACT PRISON*

June 2007

Nerelle Poroch

with support from

Julie Tongs, Peter Sharp, Mick Dodson, Steve Larkin, Katja Mikhailovich, Jodie Fisher, Ray Lovett, Kerry Arabena, John Van den Dungen, Jilpia Nappaljari Jones, Leila Smith, Jo Victoria, and Graham Henderson.

First published in 2007 by Winnunga Nimmityjah Aboriginal Health Service
63 Boolimba Crescent
NARRABUNDAH ACT 2604
www.winnunga.org.au

Copyright © Winnunga Nimmityjah Aboriginal Health Service, 2007

Printed by JP Print Management

This book printed on recycled paper

Apart from any fair dealing for the purpose of private study, research, criticism or review, as permitted under the Copyright Act, no part of this publication may be reproduced without the written permission of the publisher.

ISBN 978-0-9803945-0-4

This report is dedicated:

to the memory of one respondent who sadly passed away before this study was completed;

to the twenty-two Aboriginal and Torres Strait Islander ex-prisoners and seventeen family members of prisoners and ex-prisoners for their generosity of spirit in recounting their personal stories of incarceration;

to those who have since returned to prison;

to the community members and Winnunga Nimmityjah Aboriginal Health Service Co-researchers who assisted in the interviews;

and

to the thirty-nine representatives of Aboriginal and non-Aboriginal support organizations for generously sharing their perspectives of prison health.

Without their support the study would not have been possible.

AN ABORIGINAL EX-PRISONER'S POEM

To the whole wide world I'd love to tell
How a place on earth was a living hell
Where there's walls and bars to keep you in
It's a life you choose for wrong and sin
You wake in the morning
You hear a clang on the door
Knowing the day has begun once more
You dread the sound of keys in the lock
Only to know that it is you who's in the block
Down around island stairs, single file you walk
Then carried out in silence, Shh - ordered not to talk
But as soon you begin to wonder, are you really apart
You feel that loneliness deep down in your heart
But hey feel as though it is up to you
Your outlook on life and the things you do
If you choose to live like that
Prison soon you'll have in sight
But if you choose to live it wrong
Sad and broken your youth all gone
I've been there to see
I know what's there
The walls and bars and bolts of steel
So see it in your mind, as you can tell
On earth there is a living hell.

(1 September 2006)

CONTENTS

PREFACE	xi
ACKNOWLEDGEMENTS	xii
EXECUTIVE SUMMARY AND RECOMMENDATIONS	xiii
LIST OF ILLUSTRATIONS	xxv
LIST OF APPENDIXES	xxv
LIST OF ABBREVIATIONS	xxvi
Chapter One - INTRODUCTION	1
1.1 Background.....	1
1.2 Contribution to Aboriginal and Torres Strait Islander Prison Health.....	3
1.3 Study Overview	4
Chapter Two - THEORETICAL FRAMEWORK	7
2.1 Background – The Study’s Theoretical Framework	7
2.2 Human Rights and Treatment of Prisoners	7
2.3 Organizational Communication	9
2.4 Social Work (Holistic Care) Theory – Human Rights and Social Justice, Support Organizations.....	11
2.5 Power and Control in the Prison System	13
Chapter Three - MODEL OF ABORIGINAL HEALTH	15
3.1 Background – Aboriginal Concept of Holistic Health.....	15
3.2 Model of Aboriginal Health for the South East Region of New South Wales and the Australian Capital Territory.....	17
Chapter Four - THE STUDY METHODOLOGY	19
4.1 Background – Methods.....	19
4.1.1 Ethics.....	19
4.1.2 Co-Researchers	19
4.1.3 Literature Review.....	20
4.1.4 Interviews.....	20
4.1.5 Interview Instrument.....	21

4.1.6	Focus Group.....	21
4.1.7	Sampling	22
4.1.8	Analysis.....	22
4.1.9	Capacity Building and Team Approach to the Study.....	23
4.2	Limitations of the Study.....	23
 Chapter Five - A NATIONAL VIEW OF ABORIGINAL HEALTH AND WELLBEING		25
	Summary	25
5.1	Introduction.....	25
5.2	Aboriginal and Torres Strait Islander Population	26
5.3	The Alexander Maconochie Centre	27
5.4	Aboriginal and Torres Strait Islander Health and Wellbeing	28
 Chapter Six - A NATIONAL VIEW OF ABORIGINAL PRISONER HEALTH AND WELLBEING		31
	Summary	31
6.1	Introduction.....	31
6.2	Royal Commission into Aboriginal Deaths in Custody.....	32
6.3	Criminal Justice System.....	33
6.4	Custodial Demography - A National Picture of Indigenous Persons in Prison on the Night of 30 June 2005	34
6.5	Custodial Demography - A National Picture of Indigenous Persons in Prison for the March 2006 Quarter.....	35
6.6	Nature of Aboriginal Crime	36
6.7	Type of Intervention.....	37
6.8	Aboriginal Prisoner Health	37
6.9	Aboriginal Prisoner Health – Females.....	39
6.10	Custodial Mortality	39
6.11	Custodial Morbidity	40
6.12	Recognizing and Redressing Custodial Risk Factors	42

**Chapter Seven - AUSTRALIAN AND OVERSEAS PERSPECTIVES
OF ABORIGINAL PRISON HEALTH 45**

Summary 45

7.1 Introduction..... 45

7.2 Aboriginal Medical Services in Prisons..... 46

7.3 Winnunga Nimmityjah Aboriginal Prison Health Service Case-
Study 48

7.4 Other Aboriginal Health Services’ Prison Health Work 51

7.5 Interrelated Health Problems Arising in Prison 53

7.6 Prison Mental Health – Australian Perspectives..... 54

7.7 Prison Mental Health – Overseas Perspectives..... 56

7.8 Substance Misuse – Australian Perspectives 57

7.8.1 HIV Education in Australian Prisons 60

7.8.2 Condom Provision in Australian Prisons 60

7.8.3 Bleach Programs in Australian Prisons..... 61

7.8.4 Methadone Maintenance Treatment in Australian Prisons 61

7.9 Substance Misuse – Overseas Perspectives 62

7.10 Women Prisoners’ Health – Australian Perspectives 65

7.11 Women Prisoners’ Health – Overseas Perspectives 67

**Chapter Eight - ABORIGINAL MALE EX-PRISONERS’
PERSPECTIVES OF PRISON HEALTH 69**

8.1 Introduction..... 69

8.2 Personal Accounts of Incarceration – Male Ex-Prisoners’
Perspectives..... 69

8.3 Prison Health Care – Male Ex-Prisoners’ Perspectives 74

8.4 Mental Health and Incarceration..... 75

8.5 Mental Health and Coping with Incarceration..... 76

8.6 Mental Health and Corrective Services’ Culture 79

8.7 Drug use in Prison..... 82

8.8 Perspectives of Prison Health Services for the ACT Prison 84

**Chapter Nine - ABORIGINAL FEMALE EX-PRISONERS’
PERSPECTIVES OF PRISON HEALTH 87**

Summary 87

9.1 Introduction..... 87

9.2 Personal Accounts of Incarceration – Female Ex-Prisoners’
Perspectives..... 88

9.3 Prison Health Care – Female Ex-Prisoners’ Perspectives..... 90

9.4 Mental Health and Coping with Incarceration..... 92

9.5 Mental Health and Corrective Services’ Culture 94

9.6 Drug Use in Prison..... 96

9.7 Perspectives of Prison Health Services for the ACT Prison 98

9.8 Aboriginal Culture in Prison..... 100

**Chapter Ten - ABORIGINAL FAMILY PERSPECTIVES OF PRISON
HEALTH 105**

Summary 105

10.1 Introduction..... 105

10.2 Family Member Accounts of Prison Health..... 106

10.3 Family Member Accounts – Relatives of Ex-Prisoner
Respondents 106

10.4 Family Member Accounts – Not Related to Ex-Prisoner
Respondents 111

10.5 Perspectives of Prison Health Services for the ACT Prison 119

**Chapter Eleven - ABORIGINAL EX-PRISONER AND FAMILY
PERSPECTIVES OF SUPPORT ON RELEASE 123**

Summary 123

11.1 Introduction..... 123

11.2 Health and Wellbeing Support on Release..... 124

11.3 Settling Back into the Community on Release 126

11.4 Community Support on Release 131

11.5 Recidivism and Community Support..... 133

**Chapter Twelve - SUPPORT ORGANIZATIONS' PERSPECTIVES OF
ABORIGINAL PRISON HEALTH 141**

Summary 141

12.1 Introduction..... 142

12.2 Aboriginal Incarceration 142

12.3 Prison Health Care 148

12.4 Drug Use in Prison..... 153

12.5 Mental Health and Coping with Incarceration..... 157

12.6 Mental Health and Corrective Services' Culture 162

12.7 Perspectives of Prison Health Services for the ACT Prison 167

12.8 ACT Community Interaction - ACT Prison..... 169

12.9 Aboriginal Liaison Officers' Role - ACT Prison 172

12.10 Mental Health Issues - ACT Prison 173

12.11 Drug Issues – ACT Prison..... 176

12.12 Organizational Support for Families of Prisoners..... 177

12.13 Organizational Support for Prisoners on Release 179

12.14 Winnunga Support for Prisoners on Release 183

12.15 Support for Winnunga Holistic Care Staff..... 189

Chapter Thirteen - FINDINGS AND RECOMMENDATIONS 191

13.1 Introduction..... 191

13.2 Study Key Findings..... 191

13.3 Study Recommendations 194

13.3.1 Recommendation 1 194

13.3.2 Winnunga Holistic Health Care Prison Model 195

13.3.3 Part 1 Incarceration – Winnunga Holistic Health Care Prison
Model 197

13.3.4 Part 2 Release from Prison – Winnunga Holistic Health Care
Prison Model..... 201

13.3.5 Part 3 Managing the Cycle of Incarceration – Winnunga Holistic
Health Care Prison Model..... 205

13.3.6 Recommendation 2 – Communication Strategies..... 208

13.3.7 Recommendation 3 – Monitoring and Evaluating the Winnunga
Holistic Health Care Prison Model 209

13.3.8 Recommendation 4 – CRCAH Transfer of Knowledge and
Understanding..... 209

13.3.9 Recommendation 5 – Future Research 210

13.4	Implications for ACT Government of Winnunga Study Recommendations.....	210
13.5	Implications for Commonwealth Government of Winnunga Study Recommendations	211
BIBLIOGRAPHY		213
APPENDIXES		231

PREFACE

THE ALEXANDER MACONOCHIE CENTRE

The ACT Prison is named the ‘Alexander Maconochie Centre’ after the nineteenth century penal reformer who was commandant of Norfolk Island from 1840 to 1844.

Alexander Maconochie’s 1818 work discussing the penal colony of New South Wales, and in 1938 reporting on the state of prison discipline in Van Diemen’s Land led to his maintaining strong basic views on ‘penal science’. These were:

punishment should not be vindictively conceived but should aim at the reform of the convict, and a convict’s sentence should be indeterminate, with release depending not on the lapse of time but on their own industry and exertions during incarceration. Cruel punishments and degrading conditions should not be imposed and convicts should not be deprived of self-respect (Barry, 1967: 185-186).

During his time as commandant of Norfolk Island penal settlement Alexander Maconochie formulated and applied most of the principles on which modern penology is based. His claims that a high percentage of the convicts he discharged from the island did not offend again seem well founded.

Alexander Maconochie’s contribution to penal reform in the humane management of prisoners and many innovations in penal practice were well ahead of their time. The naming of the ACT Prison honours his memory and the many humane reforms he introduced to a brutal prison system. It also sets the tone for the ACT Prison to uphold human rights, and to focus on prisoner welfare, rehabilitation and community safety (Stanhope 2004a,b; Barry, 1967: 185-186).

ACKNOWLEDGMENTS

Winnunga Nimmityjah Aboriginal Health Service and the Prison Health Research Advisory Group wish to acknowledge and express deep appreciation to the many un-named people who have assisted in carrying out this research:

- to the funding body Healthpact, ACT Government;
- to Winnunga staff who provided liaison between the researcher and community members;
- to the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) staff who provided research and editing assistance;
- to the representatives of various organizations who offered their time to comment on the Winnunga Holistic Health Care Prison Model;
- to the independent scholars who read and commented on an earlier draft of this report; and
- to the Cooperative Research Centre for Aboriginal Health (CRAH) and the World Health Organization (WHO) appointed Commission on the Social Determinants of Health (CSDH) for selecting this research as a case-study for an International Symposium on the Social Determinants of Indigenous Health held in Adelaide in April 2007.

This study and report would not have been possible without all their assistance.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Introduction

This Winnunga Nimmityjah Aboriginal Health Service (hereafter called Winnunga) study into a best practice model of holistic health service delivery for Aboriginal inmates of the ACT Alexander Maconochie Centre has highlighted the limited national and international literature on Aboriginal and Indigenous prison health. There is also a lack of information about effective interventions to improve health outcomes, preventive health strategies, and managing the cycle of incarceration. Consequently the proposed Aboriginal Holistic Health Care Prison Model makes a significant contribution to this area of research.

The study followed the ethical guidelines of the National Health and Medical Research Council (NHMRC 2007, 2006, 2003) and the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS 2002), and received ethical approval from the AIATSIS NHMRC registered Ethics Committee. The study was endorsed by the Winnunga Board (and owner of the intellectual property rights), and the Steering Committee of Muuji Regional Centre for Social and Emotional Wellbeing. There is scope to transfer this new knowledge and understanding to the health and justice systems in other jurisdictions throughout Australia through the CRCAH of which Winnunga is a small and medium size enterprise partner. Winnunga is recognized as a leader in Aboriginal health both in the ACT region and nationally, and Winnunga's strength is the core of this Holistic Health Care Prison Model.

The findings and recommendations of this study are based on the fundamental and ethical view that the penalty for a convicted person is the removal of their freedom for the period of their incarceration, and that their basic rights as human beings in our society must be preserved, and that collective punishment on their families is unethical and unacceptable in our society (Barry, 1967: 185-186).

The existing literature and data collected from 78 respondents: 22 ex-prisoners, 17 family members of prisoners and ex-prisoners, and 39 support organization representatives have contributed to developing the Winnunga Holistic Health Care Prison Model described below. The entry criterion for

the study was any Aboriginal person, male and female who had previous experience in incarceration. Purposeful sampling was used to carry out data collection.

The Winnunga Holistic Health Care Prison Model applies a human rights and social justice framework to holistic care. It draws from and extends Green & Baldry's (2006) social work theory which recognizes Aboriginal ways of working and relating, the concept of self determination, the effects of Aboriginal history, and Aboriginal and non-Aboriginal people working in partnership. The Model also recognizes the importance of communication links between Winnunga and other Aboriginal and non-Aboriginal health, community and justice support organizations, and protects the wellbeing of Winnunga Health Workers. The following ex-prisoner's account provides an understanding of the intimidating and difficult prison environment.

'Just [coped in prison]. I would always get back in a corner and just sit there and hope for the day the sun come up that I would be released. And that wasn't that it was written on a piece of paper saying you are to stay here for your crimes against whatever ... and when you do maybe we will let you out. I was only young and it was like being taken out of the closet and thrown into humanity like into society. And when you get out into society the whole world is harsh – it is like dropping a little kitten into a pan full of pit bulls' (Ex-prisoner Interview, 1 September 2006).

This study has reported on Aboriginal health care experiences during incarceration and identified an appropriate holistic health care service delivery model with intervention strategies for Aboriginal prisoners and their families during incarceration, on release and in managing the cycle of incarceration. The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) findings and recommendations (RCIADIC 1991), and the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) policy guidelines and guidance for standards for the provision of health services to Aboriginal people in custody also provided an appropriate background to the study (SCATSIH 2005a,b).

Main Findings

The following summary of findings from the literature review and the study interview process illustrates how Aboriginal people come to be in prison and

the extent of holistic health care that is required for prisoners and ex-prisoners and their families. A separate findings section for female prisoners addresses their special needs highlighted in international and Australian literature.

Male and Female Aboriginal Incarceration

- Australian Aboriginal people are incarcerated 12 times the rate of non-Aboriginal people because of their disadvantaged and unequal position socially, economically and culturally in Australian society. Seventy-nine (79) per cent of Aboriginal prisoners are aged between 20 and 39 years.
- The average length of imprisonment is 4.8 months. Offences include: offensive behaviour and against good order offences; assault; driving and property-related offences; breach of bonds; and contempt of court.
- A greater proportion of previously incarcerated Aboriginal people are in prison than non-Aboriginal people due to a greater proportion of Aboriginal people receiving prison sentences than non-Aboriginal people. This suggests that Aboriginal community generated alternatives to prison such as community corrections, particularly for those sentenced to six months imprisonment or less, are not being used as an option of first consideration.
- The Aboriginal imprisonment rate has increased since the RCIADIC Report.
- The rate of Aboriginal prisoner deaths has exceeded the rate of non-Aboriginal prisoner deaths in eight of the fifteen years since the RCIADIC. This reflects the general overall representation of Aboriginal people in prison, and their greater vulnerability to self harm and poor health due to not accessing health services for long term health problems prior to incarceration.

Male and Female Aboriginal Prisoners' Health

- International and Australian literature research and interview data show that Aboriginal people have poor health when entering prison when compared to other prisoners. The reasons are the prevalence of poor health in Aboriginal communities and the relatively poorer access to



community health services. The stolen generations have poorer health outcomes in comparison to those who were not removed from their families.

- Specific prison health programs are required for physical, social and emotional wellbeing, primary care for diabetes, heart disease and other circulatory system diseases, respiratory diseases, women's health including sexual health, maternal and child health, mental health, alcohol and drug programs. Voluntary testing for hepatitis B and C and HIV on entry and release from prison, with informed consent and appropriate counseling, and immunization for hepatitis B should be made available.
- There is reduced capacity for prisoners to self-manage minor injuries or ailments with the assistance of families within the prison environment. In addition Aboriginal inmates access prison clinics less than non-Aboriginal inmates.
- Persons incarcerated by States and Territories do not have access to the Pharmaceutical Benefit Scheme (PBS). Entitlements under the PBS and the Commonwealth Health Care Card should not change because of their incarceration.
- The prevalence of drugs in prison was reported by both male and female study respondents, resulting in their advocacy for needle and syringe programs in prison as well as safe tattooing methods.
- Evidence to date shows Aboriginal people are generally reluctant to access health services for a host of reasons, usually waiting until their illness becomes chronic. In these circumstances, incarceration provides an opportunity for health services like Winnunga to intervene at the earlier stages of ill health. The RCIADIC findings demonstrate the need for culturally sensitive health programs that target early detection of chronic diseases, provide health promotion activities in prison and a greater awareness of holistic care in prison and in the community.

Female Prisoners' Health

- The imprisonment rate of Aboriginal women is approximately 15 times higher than the rate for non-Aboriginal women.
- There is increased satisfaction when Aboriginal women are able to access Aboriginal Medical Services in prison.
- One of the greatest impacts of imprisonment on Aboriginal women is the disruption to the family life of children, as instanced in an ex-prisoner's account:

'I just told them, don't talk to me, I don't want to know about anything and don't bother me, aye, and I should be out sooner than you think, you know. And my children coming in the prison? No way mate. Nope, because I would have been jumping that fence, and I did not want to put up with the sight of my kids hanging on to my legs and screaming and all that nuh, nuh, nuh, nuh. And that's being cruel to yourself and to your children, and it makes the time go harder' (Ex-prisoner Interview 18 September 2006).

- Lack of contact with the children impacts on the women, the children and the community who remain to care for the children.
- As well as loss of services during incarceration such as housing, medical or dental programs, an Aboriginal woman's sense of shame can be a strong barrier to accessing vital support on release and some become itinerant as a result. A major issue is the knowledge that they may lose their homes if rental payments are not maintained.
- Early intervention with Aboriginal women in the areas of education and employment, treatment for sexual and physical abuse, mental health, and alcohol and drug abuse problems would reduce contact with the criminal justice system. Aboriginal women should also be involved in developing and delivering government programs (e.g. CDEP and alcohol and substance abuse programs as well as education and economic equality initiatives) as recommended by the RCIADIC.

Aboriginal Family Member Study Respondents' Perspectives of Incarceration

- Family member respondents consider that their relatives do not cope well in prison, however they believe that the support their relatives receive from other Aboriginal inmates helps.
- Families communicate with the relatives in prison through visits, telephone conversations and letters.
- Families struggle economically in traveling to prisons for visits and staying in overnight accommodation. In addition, providing relatives in prison with sufficient funds to make telephone calls to the family is financially difficult.
- A family member explains how they are affected when their relatives are unable to break the cycle of incarceration:

'They get to be in prison through the influence of friends – they follow like sheep. Drugs and thieving, to get the money to get whatever they need and keep going. He came out looking a lot healthier than he did when he went in I can tell ya. They all come out looking nice. When he comes out it is all good at first couple of months – he thinks he is the father of the year and the best partner and everything going. Then he mingles with the people down the road and goes back to the same cycle all over again' (Aboriginal family member of prisoner, Interview 8 September 2006).

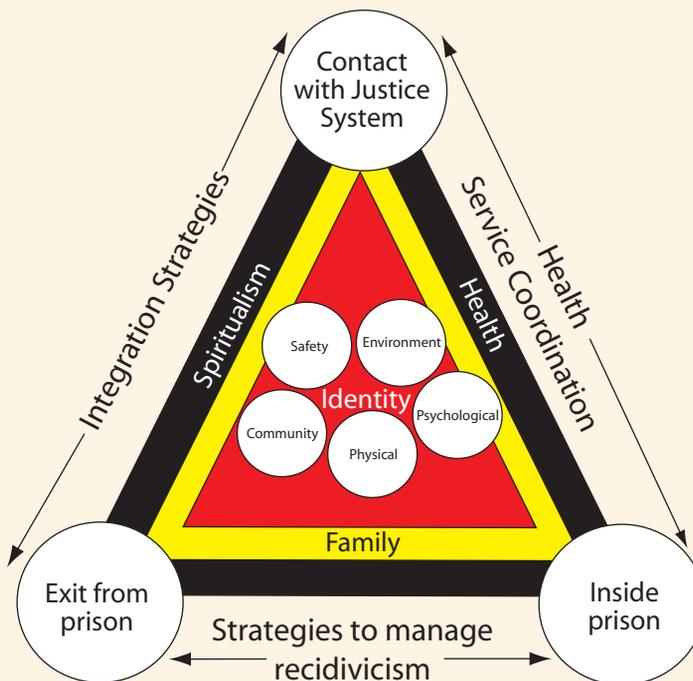
The significance of drugs and alcohol highlighted in this study's findings emphasizes the importance for the Canberra community in establishing the proposed Canberra Bush Farm. This means that Aboriginal drug users and families affected by drug use would have access to an Aboriginal-run residential treatment centre in the ACT.

Winnunga Holistic Health Care Prison Model

The Winnunga Holistic Health Care Prison Model has three parts:

- **Part 1: Incarceration** – the Model provides holistic health care during incarceration and planning for release.
- **Part 2: Release from Prison** – the Model provides post release health service coordination, and family and community reintegration strategies.
- **Part 3: Managing the Cycle of Incarceration** – the Model provides early family, and other intervention strategies.

Figure 13.3.2 shows the Winnunga Holistic Health Care Prison Model.



Source: Arabena, 2007

The Model (described in detail in Chapter Thirteen) shows that health, family and spirituality are the three supporting components of those incarcerated and upon their release into the community. At the centre of the Model is the need to develop a strong sense of identity which is crucial in coping with prison and community life. The ability to do this is dependent on the environment, safety, physical, psychological, and community support. Finally, health service coordination, and reintegration strategies into the community combine to manage the cycle of incarceration.

Increased staffing resources will be required to deliver the Winnunga Holistic Health Care Prison Model to the Alexander Maconochie Centre. The Model will be delivered by the Winnunga Prison Health Service Team, (based at Winnunga) comprising:

- 1 x Coordinator.
- 1 x Doctor – consultations once a week.
- 1 x Psychiatrist – consultations once a week.
- 1 x Dentist – twice a month service.
- 1 x Dental Assistant – twice a month service.
- 1 x Mental Health Worker – three times a week.
- 1 x Sexual Health Worker – three times a week.
- 1 x Drug and Alcohol Worker – three times a week.
- 1 x Maternal Health Worker – as required.

The Aboriginal Health Workers (male and female) would provide advocacy for Aboriginal inmates and outreach to families. They would also coordinate prison health promotion, social, emotional, and cultural programs, and prison and family liaison in conjunction with a network of Aboriginal and non-Aboriginal justice and health support organizations. The Coordinator would record details of the Alexander Maconochie Centre as well as Goulburn Prison and Cooma Prison inmates and their families for inclusion in the Team's services. This staffing level allows for the rotation of team members, and debriefing and counseling sessions to avoid burnout in an intimidating and difficult work situation. The Winnunga Holistic Health Care Prison Model also accommodates particular needs for:

1. *Post-Release Strategies* – This should be addressed as a priority at reception into prison where the focus of imprisonment should be release into an environment which provides support at the prison gate. The strategies

include accompanied transport and access to appropriate accommodation (for example, return to the family home, assisted living in a hostel, home units or houses, depending on the identified needs). Assistance will be provided in meeting Centrelink commitments, job training and gaining employment. In addition ex-prisoners will be assisted in meeting parole commitments for example, in keeping appointments, and mental health or drug and alcohol withdrawal rehabilitation commitments. The Winnunga Prison Health Service Team working with Elders and mentors in the community will provide continuity of support in prison and in reintegrating into the community and the family. These strategies also include developing strong inter-organizational relationships with health, community and justice support organizations and systematic discharge planning by the ACT Corrective Services' health service providers.

2. *Prison Harm Reduction Strategies* - In the absence of diversion from prison, and based on public health principles, human rights, and the experience in six European countries the Model includes the introduction of a needle and syringe program as part of a harm reduction strategy. Prisoners trained to provide safe tattoos, a trial air brushing tattoo program, voluntary testing (with informed consent) for hepatitis B and C, and HIV at entry into and exit from prison with appropriate counseling, and hepatitis B immunisation are important components of this strategy.

3. *Mental Health Strategies* - Transgenerational trauma is at the heart of Aboriginal incarceration. The Model addresses this by identifying Aboriginal prisoners' cultural needs to be met by the Marumali Healing Program, Listener Training, Link-Up assistance, family death and burial assistance, and Elder support in prison. These strategies, in conjunction with planning for release into a positive environment at the time of entry into prison, will assist in addressing the negative impact of the Corrective Services' environment and culture on inmates' mental health. They will also alleviate the fear of release and survival in the community as reflected in one study respondent's story:

'Every day the sooner you get out the longer the days get. That's the worst; that's when stress and everything really hits ya – the fear of getting out once you get settled. You get used to one place and it's just like being kicked out of a home. You sorta just got used to know the run of the things and how to get by and live in there. And when it is done, bang you are on your own and you've gotta do things from scratch. I've got no place to live at the moment.'

I'm on the streets. Got a wife and two kids, and I've got nothing I can do to help them because I've got no place or a roof over my head to settle down in' (Aboriginal ex-prisoner Interview, 1 September 2006).

Recommendations

The following recommendations arise directly from the study findings.

Recommendation 1. We recommend that the Winnunga Holistic Health Care Prison Model for Aboriginal inmates be incorporated into the ACT Health prison services delivered at the Alexander Maconochie Centre.

Recommendation 2. We recommend a prisoner health communication network be established between Winnunga and other Aboriginal and non-Aboriginal organizations (detailed in Chapter Thirteen). This is essential for primary health care delivery as well as social and emotional wellbeing of prisoners, ex-prisoners and their families. This should include an evaluation of the communication network.

Recommendation 3. We recommend establishing a monitoring and evaluation program for the implementation of the Winnunga Holistic Health Care Prison Model at the Alexander Maconochie Centre assessing process, impact and outcomes of the Model.

Recommendation 4. We recommend that the Cooperative Research Centre for Aboriginal Health (CRCAH) transfer this new knowledge and understanding to the health and justice systems in other jurisdictions throughout Australia.

Recommendation 5. We recommend that further studies be undertaken to help overcome the current lack of an evidence base for Aboriginal prison-related issues in the ACT and Australia. These studies (detailed in Chapter Thirteen), relate to Aboriginal people incarcerated in the Alexander Maconochie Centre, juvenile justice and effective preventative programs for Aboriginal youth, the efficacy of current sentencing options, and Aboriginal health in Police custody in the ACT.

Implications for the ACT and Commonwealth Governments

The implications for the ACT Government are:

- allocating funding for Winnunga Nimmityjah Aboriginal Health Service to deliver the Winnunga Holistic Health Care Prison Model;
- allocating funding for a community-based hostel and units or houses for Aboriginal ex-prisoners and their families, and families visiting relatives in prison;
- allocating funding for the Aboriginal-run Canberra Bush Farm residential treatment centre for Aboriginal drug users and their families;
- allocating funding for a bus service to visit relatives in Cooma and Goulburn Prisons, and the Alexander Maconochie Centre;
- authorizing a Memorandum of Understanding (MOU) for guaranteed access by Aboriginal inmates to Education and Rehabilitation Prison Programs;
- authorizing an MOU for guaranteed family access visits and family days to the Alexander Maconochie Centre (AMC);
- authorizing Cultural Awareness Training for Corrective Services' staff of the AMC;
- authorizing Cultural Awareness Training for Australian Federal Police Officers;
- establishing a Complaints Process for Aboriginal prisoners of the AMC;
- establishing an Aboriginal Prisoners' Advocacy Group;
- authorizing routine voluntary testing (with informed consent) for hepatitis B (and immunization where relevant), hepatitis C and HIV on entry to and exit from the AMC;
- establishing a needle and syringe program within the AMC; and
- authorising increased Aboriginal teachers and Aboriginal education officers in ACT schools.

The implications for the Commonwealth Government are:

- assuming the role of setting mandatory national standards for best practice in health service delivery in all prisons;
- specifying that Health Departments rather than Corrections deliver health services throughout Australia;
- allowing persons incarcerated by States and Territories access to the Pharmaceutical Benefit Scheme (PBS). Entitlements under the PBS and the Commonwealth Health Care Card should not change because of their incarceration.
- reinstating prisoners' federal election voting rights rescinded with the introduction of the Electoral and Referendum Amendment (Electoral Integrity and Other Measures) Act 2006.

LIST OF ILLUSTRATIONS

FIGURE 2.3.1	The Muuji Regional Centre for Social and Emotional Wellbeing notional geographical area	10
FIGURE 5.2.1	The Aboriginal and Torres Strait Islander and Total Population of Australia in 2001, by Age and Sex	26
FIGURE 13.3.2	The Winnunga Holistic Health Care Prison Model	195

LIST OF APPENDIXES

APPENDIX A	Interviews Ex-prisoner and Family Members	232
	Interviews Support Organization Representatives.....	235
APPENDIX B	Articles on the Declaration on the Rights of Indigenous People Relating to Aboriginal Prisoners (selected Articles).	238
APPENDIX C	Interviews and Focus Group Questions:	
	Ex-prisoners	241
	Families of Prisoners and Ex-Prisoners	245
	Representatives of Support Organizations	250
APPENDIX D	Participant Consent Form	255
APPENDIX E	Research Study Information Sheet	257

LIST OF ABBREVIATIONS

AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
ACLO	Aboriginal Community Liaison Officer
ACT	Australian Capital Territory
AFP	Australian Federal Police
AHC	Australian Hepatitis Council
AHMAC	Australian Health Ministers' Advisory Council
AHS	Aboriginal Health Service
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIC	Australian Institute of Criminology
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AJAC	Aboriginal Justice Advisory Council
AJC	Aboriginal Justice Centre
ALO	Aboriginal Liaison Officer
ALRC	Australian Law Reform Commission
AMA	Australian Medical Association
AMC	Alexander Maconochie Centre
AMS	Aboriginal Medical Service
ANU	Australian National University
BRC	Belconnen Remand Centre
CAAN	Canadian Aboriginal AIDS Network
CCRTS	Correctional Centre Release Treatment Scheme
CDEP	Community Development and Employment Program
CEO	Chief Executive Officer
CRCAH	Cooperative Research Centre for Aboriginal Health
CSC	Correctional Service Canada
CSDH	Commission on Social Determinants of Health
DNA	Deoxyribonucleic Acid
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HREOC	Human Rights and Equal Opportunity Commission
HRSCATSIA	House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
MOU	Memorandum of Understanding
MRRC	Metropolitan Remand and Reception Centre

Muuji	Muuji Regional Centre for Social and Emotional Wellbeing
NACCHO	National Aboriginal Community Controlled Health Organization
NAHSWPR	National Aboriginal Health Strategy Working Party Report
NAIDOC	National Aborigines and Islanders Day Observance Committee
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NDARC	National Drug and Alcohol Research Centre
NHMRC	National Health and Medical Research Council
NSW	New South Wales
NSWAJAC	New South Wales Aboriginal Justice Advisory Council
NT	Northern Territory
OA & NACCHO	Oxfam Australia & National Aboriginal Community Controlled Health Organization
PHST	Prison Health Service Team
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SA	South Australia
SCATSIH	Standing Committee on Aboriginal and Torres Strait Islander Health
TAFE	Technical and Further Education
UK	United Kingdom
UN	United Nations
USA	United States of America
WA	Western Australia`
WHO	World Health Organization
Winnunga	Winnunga Nimmityjah Aboriginal Health Service
WPA	World Psychiatric Association



Chapter One - INTRODUCTION

1.1 Background

This study develops a best practice model of holistic health service delivery for Aboriginal inmates of the new Alexander Maconochie Centre in the Australian Capital Territory (ACT). The Australian Bureau of Statistics (ABS) Census in 2001 showed there were 3,941 Aboriginal and Torres Strait Islander people in the ACT, 1.2 per cent of the total ACT population of 321,680 (ABS 2002). A recent report (ABS 2005) provided a picture of persons in prison in Australia as at 20 June 2005. This showed there were 17 Aboriginal people housed in Belconnen and Symonston Remand Centres for unsentenced prisoners in the ACT. In addition, there were 9 Aboriginal people sentenced to full-time custody by the ACT being held in NSW prisons (ABS 2005: 13, 36). While the ACT commenced detaining some sentenced fine-default-only prisoners at the remand centres during 2000, persons sentenced to full-time custody by the ACT are usually held in NSW prisons. However, some unsentenced ACT individuals on remand are held in NSW prisons when the capacity of the ACT remand centre is exceeded (ABS 2005: 36-37).

The study's theoretical framework of human rights in delivering holistic care to Aboriginal inmates of the Centre is in line with the ACT Government's groundbreaking work as the first jurisdiction in Australia to establish a Bill of Rights in 2004 (ACTG 2004). The commitment of Winnunga Nimmityjah Aboriginal Health Service to human rights for Aboriginal people was reflected in a subsequent Roundtable discussion with Paul Hunt (the UN Special Rapporteur on the Right to Health) at Winnunga in 2006 (<http://www.ohchr.org/english/issues/health/right/index.htm>). The Special Rapporteur explores the right to health through two inter-related themes of poverty and the right to health, and stigma and discrimination and the right to health. The Roundtable discussed the right to health and its significance for Aboriginal people. It also questioned whether Aboriginal health advocates should be pressing for the inclusion of economic, social and cultural rights, such as health in the ACT Human Rights Act 2004 (Winnunga 2006). The removal of prisoners' voting rights has also been a controversial issue both in Australia and overseas (Davidson, 2004).

In developing the Winnunga Holistic Health Care Prison Model, Winnunga and its partners: Muuji Regional Centre for Social and Emotional Wellbeing;

AIATSIS; the National Centre for Indigenous Studies at The Australian National University; the Healthpact Research Centre for Health Promotion and Wellbeing at the University of Canberra; The Connection ACT; and the CRCAH have worked toward providing a solid basis to better inform health care practices. This means creating a harm minimization or risk reduction environment for Aboriginal inmates, their families, and Aboriginal health service providers in the wider custodial environment throughout Australia. The CRCAH, of which Winnunga is a small and medium size enterprise partner, will help transfer this new knowledge and understanding to the health and justice systems in other jurisdictions throughout Australia.

The goals of the study are to answer four research questions. They are:

- *What are the health and cultural considerations of delivering holistic health care services for Aboriginal inmates in the ACT Alexander Maconochie Centre?*
- *What are the specific health services required for holistic health care service delivery to Aboriginal inmates in the ACT Alexander Maconochie Centre?*
- *What are the health service implications for Winnunga Nimmityjah Aboriginal Health Service?*
- *Who are the other organizations involved in providing services and the communication requirements between these organizations?*

The objectives of this study are:

- To analyse the existing literature and models of healthcare delivery, both national and international, with a particular focus on Aboriginal peoples in custodial settings;
- To obtain primary source qualitative data from key stakeholders;
- To collate and synthesize the findings to determine good practice;
- To develop and provide recommendations for implementation of best practice holistic health care delivery to Aboriginal inmates of the ACT Alexander Maconochie Centre;
- To promote the findings to other jurisdictions throughout Australia to inform best practice both locally and nationally;
- To promote the findings internationally through the WHO Commission on the Social Determinants of Health; and

- To use best practice methodologies for community engagement, participatory action research, capacity building, and community development to support the preceding objectives.

1.2 Contribution to Aboriginal and Torres Strait Islander Prison Health

The study considers the whole of life view of Aboriginal peoples incarcerated in Australian prisons. The families of prisoners and health care workers directly involved in the care of prisoners are also recognized in this health care model along with the specific cultural needs of prisoners. The assertion of this study is that from the knowledge gained by Winnunga in providing a health service to Aboriginal inmates in the Goulburn Prison (NSW), Cooma Prison (NSW), Belconnen and Symonston Remand Centres (ACT), it is important that a best practice model of holistic health service for Aboriginal inmates of the Alexander Maconochie Centre in the ACT be developed prior to it becoming operational in mid 2008. Consequently, Winnunga initiated this project to undertake research with selected partners to develop a holistic health care delivery model. It will inform government about how to improve the appropriateness and effectiveness of health care delivery to Aboriginal inmates of custodial institutions.

The study draws on Australian as well as overseas literature about Aboriginal prison health in Canada, New Zealand and the USA, and mainstream prison populations in Europe, the UK, Canada and the USA. Aboriginal people comprise 2.7 per cent of the adult Canadian population. However, approximately 18.5 per cent of offenders in prison are of First Nations, Metis and Inuit ancestry (CSC 2005). The Aboriginal prison population is a high needs group which shares a background of physical or sexual abuse, early drug and alcohol use, emotional problems, poor parenting and high educational and employment needs (CSC 2006). In New Zealand 50 per cent of prisoners are Maori and 8.3 per cent are of Pacific Island ethnicity. There is an over-representation by these two groups, with Maori being 14.1 per cent of the general population and Pacific peoples 6.2 per cent. Characteristics of the backgrounds of Maori and Pacific Island offenders include poverty, marginalization, poor educational achievement, broken homes, large family size, male gender and history of abuse (Simpson et al. 2003). The number of American Indians per capita confined in USA state and federal prisons are approximately 38 per cent above the national average. However, the rate of confinement in local gaols is estimated to be almost four times the national

average (USADJ 1999). The UK, European, Canadian and USA mainstream prison health literature is particularly relevant to mental health, substance abuse, communicable diseases, and women's health.

1.3 Study Overview

Chapters Two to Four address the background to the study - the Theoretical Framework, the Model of Aboriginal Health and the Study Methodology. Chapters Five to Twelve present the findings of the study. For example Chapters Five and Six describe Aboriginal Australians' general health and prison health and wellbeing, while addressing Research Question 1: *What are the health and cultural considerations of delivering holistic health care services for Aboriginal inmates in the ACT Alexander Maconochie Centre?*

Chapter Seven presents a case-study of Winnunga focusing on the current health services it delivers to the Goulburn and Cooma Prisons in NSW, and the Belconnen and Symonston Remand Centres in the ACT, and further analyses Research Question 1. Chapter Seven provides further information on the health services delivered by Aboriginal Health Services in other Australian jurisdictions. Chapter Seven also examines the particular health requirements for Aboriginal Australians in prison while comparing their situation with Aboriginal people overseas and with mainstream prison populations in Europe, UK, Canada and the USA.

Chapters Eight, Nine and Ten address Research Question 2: *What are the specific health services required for holistic health care service delivery to Aboriginal inmates in the ACT Alexander Maconochie Centre?* This is examined from the perspectives of Aboriginal male and female ex-prisoners (Eight and Nine) and families of ex-prisoners and prisoners (Ten). Chapter Ten also addresses Research Question 1.

Chapter Eleven examines ex-prisoner and family perspectives of the support they received on release from prison. It follows Research Questions 2, and also 3 and 4 – Research Question 3: *What are the health service implications for Winnunga Nimmityjah Aboriginal Health Service?* and Research Question 4: *Who are the other organizations involved in providing services and the communication requirements between these organizations?*



Chapter Twelve examines the perspectives of support organization representatives who support families, prisoners and ex-prisoners on release and follows the Research Questions for Chapter Eleven. Chapter Thirteen presents the study's findings and recommendations.



Chapter Two - Theoretical Framework

2.1 Background - The Study's Theoretical Framework

The theoretical framework for this study is mainly found in scholarship about human rights and social justice, social work development (i.e. 'holistic care') for Aboriginal Australians, and organizational communication. The Aboriginal and Torres Strait Islander Social Justice Commissioner in his Social Justice Report 2005 (HREOC 2005: 10) notes the 'substantial inequalities that exist between Aboriginal Australians and Non-Aboriginal Australians, particularly in relation to chronic and communicable diseases, infant health, mental health and life expectation'. He also highlights the need to redress undiagnosed and untreated health problems of Aboriginal Australians particularly regarding mental health, and oral/dental health which do not receive adequate attention in health programs. This situation is reflected in the health of Aboriginal people who are incarcerated in Australian jurisdictions. In writing about his development of an intellectual position to explain contemporary reality of the modern world-system, Wallerstein refers to Fanon's work in the 1960s which represented for him 'the sharp culmination of the insistence by the persons left out in the modern world-system that they have a voice, a vision, and a claim not merely to justice but to intellectual valuation'. Prigogine's work over four decades (1960s to 1990s) forced Wallerstein 'to face all the implications of a world in which certainties did not exist but knowledge still did' (Wallerstein 2000: 1-7). These ideas are found in the theoretical framework of this study, the basis of which is human rights, and is outlined in the following sections.

2.2 Human Rights and Treatment of Prisoners

The United Nations (UN) Standard Minimum Rules for the Treatment of Prisoners (UN 1955) stipulate that 'the religious beliefs and moral precepts of the group to which a prisoner belongs' must be respected; 'the rules will be applied impartially'; and '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 state:

22. (3) 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. (1) 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 attention is specially directed (see <http://www.ohchr.org/english/law/treatmentprisoners.htm>).

In the wider context of Aboriginal peoples' rights, the UN Committee on Economic Social and Cultural Rights provides for Aboriginal Australians and non-Aboriginal Australians' enjoyment of 'the highest attainable standard of health conducive to living a life in dignity' (UN 2000, para 1). On 29 June 2006 the UN Human Rights Council adopted the Declaration on the Rights of Indigenous Peoples (UN 2006). Included in the recommendations for its adoption by the General Assembly are Articles (below) which are relevant to Aboriginal prisoners. A comprehensive listing of relevant Articles is shown in Appendix B.

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 (see <http://www.ohchs.org/english/issues/indigenous/docs/declaration.doc>).

In 2004 the ACT Government (ACTG 2004) was at the forefront in Australia in establishing the ACT Human Rights Act, the preamble of which states:

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.

In the spirit of human rights and social justice, the NHMRC has developed a strategic framework for improving Aboriginal people's health through research (NHMRC 2004). The framework identifies six research themes critical to achieving substantial gain for Aboriginal people. One theme has 'a focus on engaging with research and action in previously under-researched Aboriginal and Torres Strait Islander populations and communities'. One draft research question which is relevant to this study asks: 'What are the issues in the cycle of incarceration experienced by many individuals and communities: before, during and after prison?' Consequently, following the NHMRC guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (NHMRC 2003: 22) this study

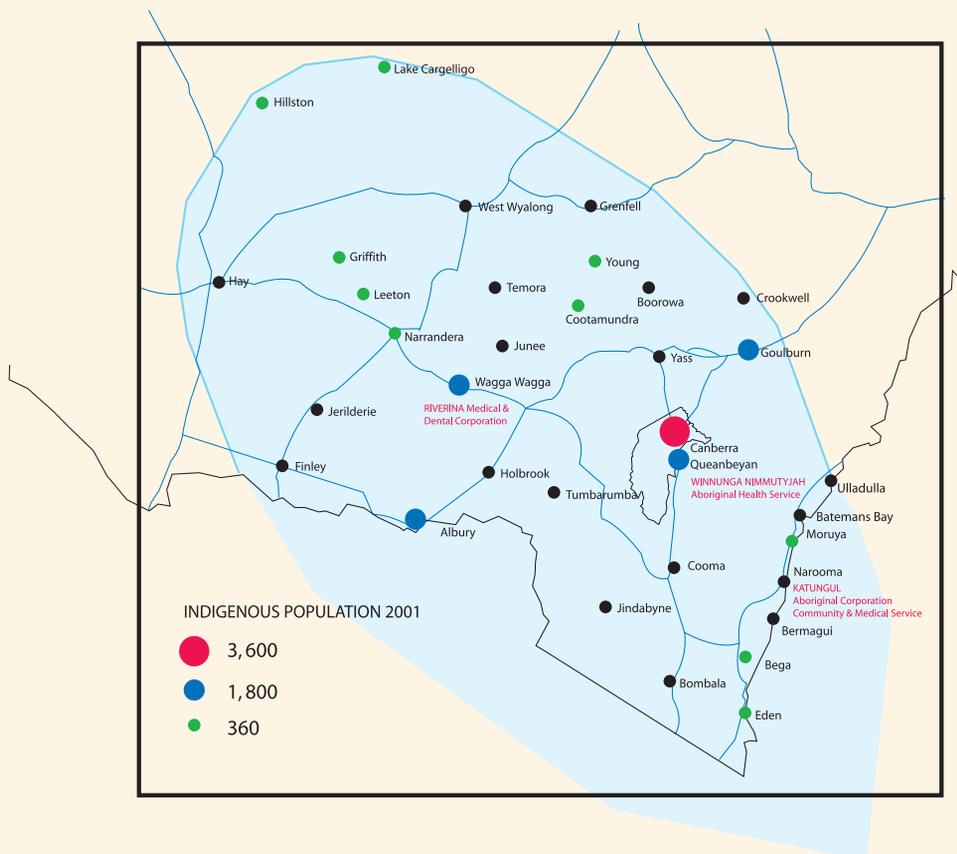
develops the capacity of Aboriginal community controlled health services to undertake their own research and participate directly in research using the significant amount of vital information that they hold and which could contribute to health strategies and better understanding of the role of the Sector in health generally.

2.3 Organizational Communication

Winnunga applies a life course approach to healthcare as well as attending to primary health care. It encompasses social, emotional, spiritual and cultural needs including preventative care, pharmaceuticals, transport support and prison care (see Winnunga case-study in Chapter Seven). This means that Winnunga has significant interaction with other support organizations including those related to drug and alcohol, domestic violence, Centrelink, accommodation, mental health, and the justice system. In the instance of health care for prisoners and their families, the Winnunga Chief Executive Officer (CEO) and medical and health workers link the organization with its external social environment.

Based on Winnunga’s community involvement the CEO estimates that there are about 5,000 Aboriginal people in the ACT, plus thousands more in the South East region of NSW surrounding the ACT. Figure 2.3.1 shows this region extending from Crookwell in the north to the Victorian border in the south, from Young and the Snowy River in the west, and from Batemans Bay along the coast to the border with Victoria (Dukes et al. 2004).

Figure 2.3.1 The Muuji Regional Centre for Social and Emotional Wellbeing notional geographical area¹.



¹ Muuji Regional Centre for Social and Emotional Wellbeing is a consortium of 3 Aboriginal Community controlled Health Services, and is auspiced by Winnunga (Muuji undated).

Interaction within the ACT and region is related to the role of ‘boundary spanners’ – organizational members who serve in roles that require exchange with the environment (Lewis & Slade 2000). Boundary spanners face many communicative challenges within this particular organizational environment. They include providing medical and social support to clients, and acquiring operational information for decision making in external communication with other support organizations. They also remain alert to unpredictable information, for example new initiatives such as the introduction of a prison in the ACT that could impact on future organizational operations.

Holistic care involves communicating interpersonally with clients and patients. Resultant stressors can create a strain on medical and health workers called burnout which can lead to negative psychological, physiological and organizational outcomes. The term burnout is a ‘wearing out’ from the pressures of work (Freudenberger 1974). Individuals often choose occupations of health care or social work because they are people oriented and feel a high degree of empathy for others. They feel two kinds of empathy i.e. emotional contagion (feeling with another) or empathic concern (feeling for another) (Pines 1982). Miller et al. (1995) found the former orientation is likely to experience burnout whereas the latter orientation (akin to detached concern) is unlikely to suffer the effects of burnout. The organization can assist in reducing burnout by clearly defining the employee’s role, monitoring and controlling the workload and encouraging ‘time outs’ during the workday and time off from work to recharge. In addition, an employee’s real and perceived sense of influence and control, and social support received from supervisors, co-workers, friends and family can decrease job-related strain (Miller 1999: 277-231). It is important that health workers understand Aboriginal ways of knowing. This study substitutes the term ‘holistic care’ for the term ‘social work’ in extending Green & Baldry’s (2006) social work theory, and draws from Indigenous research academy in Australia, Canada and New Zealand, discussed in the following section.

2.4 Social Work (Holistic Care) Theory - Human Rights and Social Justice, Support Organizations

The social work profession follows the principle of social justice. It promotes distributive justice and social fairness. The aim of social workers is to ‘reduce barriers and expand choice and potential for all persons, with special regard for those who are disadvantaged, vulnerable, oppressed, or have exceptional

needs' (AASW, 2002: 3.2.1a). From an Australian perspective Green & Baldry (2006) consider that striving for excellence in delivering social work includes the knowledge that building Aboriginal Australian social work theory and practice is 'based solidly in and guided by Indigenous Australians' participation and experience and has at its heart human rights and social justice'.

This study extends Green & Baldry's (2006) Aboriginal social work theory by proposing that the term 'holistic care' be used in place of 'social work' to better relate Aboriginal theory to the health needs of Aboriginal prisoners. The social determinants and lived reality of Aboriginal people reflect the disadvantaged and unequal position of Aboriginal people, socially, economically and culturally in Australian society. This commenced with colonization and dispossession, stolen wages and stolen generations. These events led to disempowerment, loss of self determination, marginalization, racism and loss of culture and identity. In the context of this prison health study they are the underlying factors in the part played by drugs and alcohol in criminal activity. They are the 'causes of the causes' for Aboriginal Australians' incarceration necessitating holistic care delivery by Aboriginal Medical Services nationally.

Social and cultural changes experienced over generations have affected the development of a sense of identity by Aboriginal people, as traditional family and social roles of adult males have been lost in persistent unemployment that has become the role model for youth (Beresford & Omaji 1996: 126). As a result females are assuming this responsibility in lone parenting, or lobbying government, community and the Police on issues such as family violence (Neill 2002: 100). Identifying as an Aboriginal person is difficult for young people, as they are often unable to learn this culture from their parents. The consequences are that the struggle over identity, together with cultural dispossession, is manifested in pessimism, defeatism, poor self image and an inability to find a sense of belonging and acceptance (Beresford & Omaji 1996: 127).

From a Native Canadian perspective, Sinclair (2002: 56) describes Indigenous social work as:

... a practice that combines culturally relevant social work education and training, theoretical and practice knowledge derived from Aboriginal epistemology (ways of knowing) that draws liberally on western social work theory and practice methods, within a decolonizing context.

From a Maori social justice perspective Smith (1999: 183, 190) considers that Kaupapa Maori research sets:

new directions for the priorities, policies and practices of research for, by and with Maori. Recognition of the failure of medical research to address the needs of Maori in health ... has shifted some areas of health research towards, first, developing more culturally sensitive research, and, second, employing Kaupapa Maori approaches. These include the involvement of Maori researchers in large studies, and the establishment of Maori health research units and centres which focus on issues of Maori health, are managed and organized by Maori, and employ multidisciplinary approaches within a Kaupapa Maori framework.

These approaches follow Foucault's (1980) idea that knowledge – that is, the truth – sets people free. He also argues however, that knowledge and truth result from power struggles and are used to legitimate the way power is used for example in the prison system, as discussed below.

2.5 Power and Control in the Prison System

Harsh government policies of the past affecting Aboriginal Australians which were about segregation and stolen children have translated into feelings of distrust, shame, shyness, and the perception of prejudice. They relate to the central topic of Foucault's ideas about the struggle of individuals against the power of society, the role of prisons in society, and how the discipline they enforce controls those who are incarcerated in them (McGaha, 2000).

According to Foucault (1975: 265, 266, 267, 268):

Prisons do not diminish the crime rate: they can be extended multiplied or transformed, the quantity of crime and criminals remains stable or, worse, increases ... Detention causes recidivism; those leaving prison have more chance than before of going back to it; convicts are, in a very high proportion, former inmates.

The prison cannot fail to produce delinquents. It does so by the very type of exercise that it imposes on its inmates: whether they are isolated in cells or whether they are given useless work, for which they will find no employment, it is, in any case, not 'to think of man in society; it is to create an unnatural, useless and dangerous existence'. ... The prison also produces delinquents by imposing violent constraints on its inmates; it is supposed to apply law, and to teach respect of it; but all its functioning operates in the form of an abuse of power. The arbitrary power of the administration

The prison makes possible, even encourages, the organization of a milieu of delinquents, loyal to one another, hierarchized, ready to aid and abet any future criminal act. The conditions to which the free inmates are subjected necessarily condemn them to recidivism: they are under the surveillance of the police; they are assigned to a particular residence, or forbidden others.

Lastly, the prison indirectly produces delinquents by throwing the inmate's family into destitution

The documents which have informed this theoretical approach include the National Aboriginal Health Strategy (NAHSWP 1989); Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991); The Ways forward. National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health (Swan and Raphael 1995); Bringing Them Home Report (HREOC 1997); National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003a,b); and the Australian Health Ministers' Advisory Council (AHMAC) Draft Policy Guidelines for the Provision of Health Services to Aboriginal and Torres Strait Islander People in Custody, including the Draft Guidance on Operational Standards for the Provision of Health Services to Aboriginal and Torres Strait Islander People in Custody (SCATSIH 2005a,b). It should be noted that in Australia, prisons are the responsibility of the States and Territories. Consequently, in the absence of Commonwealth involvement there are difficulties in influencing prison health nationally.

Chapter Three - Model of Aboriginal Health

3.1 Background - Aboriginal Concept of Holistic Health

Culture and identity are central to Aboriginal perceptions of health and ill-health. How Aboriginal people view wellness and illness is in part based on cultural beliefs and values. At the service interface these perceptions and the social interaction surrounding them influence when and why Aboriginal communities access services, their acceptance or rejection of treatment, the likelihood of compliance and follow-up, the likely success of prevention and health promotion strategies, the client's assessment of the quality of care, and the views of health care providers and personnel. In 2005 the President of the Australian Medical Association (AMA) Dr Bill Glasson, acknowledged that Aboriginal people were forced to navigate an alien health structure that was too often counter cultural. He considered there was a need for a holistic approach to deliver Indigenous Australians the basics of life, and the quality of life that the rest of Australia takes for granted (Winnunga undated). This idea of holistic health including a healthy lifestyle, healthy body, social and emotional health, cultural and spiritual health, and economic circumstances is further examined in the following section.

Western medicine has used two different ways of understanding diseases and the people who have them. One way emphasizes the natural history of disease. The other way emphasizes the experience of the patient. In his study of holism and the idea of general susceptibility to disease Kunitz (2002: 727) concludes that ideas about holism and general susceptibility to disease may be seen as a continuation of the tradition of emphasizing the experience of the patient, in opposition to the dominant tradition of emphasizing the natural history of disease.

Swan and Raphael (1995 Part 1:1) wrote in the executive summary of their National Consultancy Report on Aboriginal people's mental 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.

Lutschini's (2005) review of holism in Australian Aboriginal health policy found that the concept of holism is frequently related to the definition of health used by the National Aboriginal Health Strategy Working Party (NAHSWP 1989: ix):

Health is the social, emotional, and cultural well-being of the whole community – not just the physical well-being of the individual. This is a whole-of-life view and includes the cyclical concept of life-death-life.

Lutschini (2005) concluded that in order to enable more effective transfer of meanings into Australian health policy making, the incapacity to coherently articulate Aboriginal concepts of health prevents advisory bodies such as the National Aboriginal and Torres Strait Islander Health Council (NATSIHC) to instigate whole of government approaches which accord with Aboriginal values. He considers that this situation could be addressed through communication - written and oral - and further research to redress the current negative health outcomes for Aboriginal people.

In the context of the health of Aboriginal prisoners in Australia, Cunneen's (2002: 38) discussion paper proposes a New South Wales Aboriginal Justice Plan which takes a holistic approach to preventing Aboriginal offending behaviour before it occurs and provides programs aimed at stopping re-offending. His ideas of holistic models of Aboriginal crime prevention overlap holistic health models and propose that:

- Holistic models and services focus on the social, emotional, physical and spiritual wellbeing of people. They combine these different elements in an overall approach for finding solutions to problems;
- Holistic models develop Indigenous-specific programs that stress issues relating to Indigenous culture and history; and
- Holistic models look to the development of the Aboriginal individual, family and community by providing culturally sensitive programs and services, by using Aboriginal concepts where appropriate, and by promoting the fair and equitable treatment of Aboriginal people.

Cunneen also cautions that a continuing thread in Aboriginal holistic approaches is the recognition of Aboriginal self-determination. Consequently programs must be designed with the objective of enabling Aboriginal people to take charge of all aspects of their own lives. He also considers that input and assistance from a range of government agencies may be required in achieving a holistic approach (Cunneen 2002: 38). In conjunction with the communities in the Muuji geographical area, this study has extended scholarship in Aboriginal health models by developing a model of health for the South East Region of New South Wales and the ACT as detailed in the following section.

3.2 Model of Aboriginal Health for the South East Region of New South Wales and the Australian Capital Territory

In conjunction with the Muuji Regional Centre for Social and Emotional Wellbeing, a local Aboriginal Model of Health is being developed by community members of the South East Region of New South Wales and the ACT. Muuji comprises a consortium of three Aboriginal community controlled health and medical services in Canberra ACT, Wagga Wagga and Narooma in NSW. Finalisation of the Model is expected prior to the opening of the Alexander Maconochie Centre, following wide consultations with the Muuji Steering Committee, staff of the three Aboriginal Medical Services in this region, the region's Aboriginal community, and the Muuji Forum in Canberra in May 2007. This Model will extend Aboriginal health research to enhance the delivery of a holistic health service to Aboriginal prisoners. It also complements the study's theoretical framework which incorporates Foucault's ideas about knowledge, power and control; the human rights and social justice theoretical framework in Aboriginal holistic care and health; organizational communication in addressing appropriate communication between support organizations; and burnout experienced by medical and health workers. The Model draws on primary data in examining the interactions of these ideas with the perceptions and experience of Aboriginal ex-prisoners and families of prisoners, and the organizations which support Aboriginal prisoners, ex-prisoners and their families.



Chapter Four - The Study Methodology

4.1 Background - Methods

4.1.1 Ethics

This study follows the ethical guidelines of the NHMRC (2003; 2006; 2007) and AIATSIS (2002), and will contribute to Aboriginal Australians' prison health by providing a framework of holistic health service delivery for Aboriginal inmates at the new ACT Prison, and influence other facilities in all jurisdictions in Australia. The study received ethical approval from the AIATSIS NHMRC Registered Ethics Committee. All requirements of the Ethics Committee including informed consent and confidentiality rights were carried out prior to and following Co-researcher training (described below), and each in-depth interview and focus group. This study adhered to the principles of biomedical ethics, namely respect for autonomy, beneficence, non-maleficence, and justice, plus attention to their scope of application (Beauchamp & Childress 2001).

The research project was endorsed by the Winnunga Board and the Muuji Steering Committee. The intellectual property rights will remain with Winnunga. Access to and use of the findings can be negotiated with Winnunga.

This qualitative case-study of holistic health service delivery to Aboriginal inmates of the ACT Alexander Maconochie Centre describes the experiences of ex-prisoners and families of prisoners in the ACT Remand Centres and NSW Prisons in accessing prison health services. Patton (1990) considers that case studies are particularly useful in understanding some special people, a particular problem, or a unique situation in great depth and where a great deal can be learned from a few examples of the phenomenon investigated. (Case-studies are used very widely in medicine for the same reason).

4.1.2 Co-researchers

Four participants from The Connection, three community members, and four Winnunga Aboriginal Health Workers attended a one-day training course in co-research techniques. The Connection is an organization administered by Aboriginal ex-drug users for Aboriginal users. (The participation of its

members in the study has provided future opportunities for capacity building in staff training cadetships). The community members have experience of family members' incarceration, and the Winnunga staff were able to draw from their experience as community Health Workers. The Winnunga Health Workers were instrumental in the success of the interviewing process in suggesting that community members be trained as Co-researchers, firstly to provide a safe and trusting interview environment in partnership with the non-Aboriginal researcher, and secondly because of their potential to contact interviewees. The community Co-researchers were remunerated \$100 for participating in the training day, and \$100 for each interview conducted. The interview and focus group ex-prisoner and family respondents each received a gift of \$20.

4.1.3 Literature Review

The study examined Australian literature about Aboriginal prison health and compared this with Aboriginal prison health in the comparable countries with liberal democracies, New Zealand and Canada. The study literature search highlighted the paucity of other studies which examine Aboriginal prisoners' health needs. This included multiple keyword searches of major electronic databases, manual searching of references in published and unpublished articles, reports and texts. However, the UK, European, Canadian and American literature contributed to an emerging body of knowledge on Aboriginal prison health in its attention to mainstream prison population experiences in mental health, substance abuse, communicable diseases, and women's health.

4.1.4 Interviews

The ex-prisoner and family interviews were conducted at Winnunga and at a Co-researcher's residence. The support organization representatives were interviewed at Winnunga or their business address. The respondents have not been identified by name. The support organization representatives are identified numerically and the ex-prisoners and family respondents alphabetically to observe confidentiality. Attaching numbers to ex-prisoners and families was considered inappropriate due to prisoners being identified by a number. All interviews with ex-prisoners and family members were tape recorded over a session which averaged forty-five minutes. The same procedure was followed for the support organization representatives and the focus group apart from nine support organization representatives' interviews which were not tape recorded due to inappropriate venues and personal preference.

4.1.5 Interview Instrument

Individual interview instruments were designed for each group i.e. ex-prisoners, families, and the support organization representatives (see Appendixes B, C, D & E for Interview Questions, Informed Consent Form, and Research Study Information Sheet). The main ideas of the interviews and focus group were tested in pilot interviews to confirm the importance and meaning of possible patterns and to verify the viability of emergent findings. Corrections were made where necessary. This process revealed that providing the information in story fashion was favoured by the Aboriginal respondents, and consequently, the interviews and focus group questions were refined into themes for discussion with specific areas to be canvassed for each theme. Fourth generation evaluation was observed in exploring a methodology that offered equal voice to the consumers and professional stakeholders (Guba & Lincoln 1989). Anticipation of lack of trust in the non-Aboriginal researcher was alleviated by the presence of Aboriginal Co-researchers unless otherwise requested by the respondents. The respondents' generosity in recounting difficult experiences was acknowledged by the researchers in the interview process and subsequently, in the feedback to the study participants and community members.

4.1.6 Focus Group

Following Lunt & Livingstone (1996) that conversation is important to developing everyday life meanings and understanding, the study included one focus group comprising five participants. The Nannies' Group focus group was conducted in an informal domestic setting around the table. It comprised five grandmothers concerned about the incidence of drugs and alcohol leading to high recidivism rates amongst young Aboriginal people in the community. The Group identifies and redresses gaps in community support, and supports ACT prisoners and community members who are victims of domestic violence and are struggling with drug and alcohol habits. Their work also contributes towards diverting young community members away from drugs and alcohol and associated offences. One member was a Co-researcher in the study. She was approached by Winnunga staff to assist in the study because of her experience in providing assistance to community members taken into Police custody. She is also a Board member of the Aboriginal Justice Centre (AJC). Three focus group members had children who had been or were currently in prison. The common objective within the group meant that their responses

were complete and less inhibited, and links of thinking that might have not been brought up in a one-to-one interview were stimulated by the remarks of others in the group (Wimmer & Dominick 1994).

4.1.7 Sampling

The entry criterion for the study was any Aboriginal person, male and female who had previous experience in incarceration. Purposeful sampling was used to carry out data collection of a total of 78 respondents: 22 were ex-prisoners (15 male and 7 female); 17 were family members of prisoners (5 male and 12 female); and 34 were support organization representatives, and one focus group comprising 5 members (detailed at Appendix A). The exact number or type of interviews was left open in the realization that numbers change over time as data are discovered and interpreted. Consequently the samples were smaller, more purposive than random, and subject to change and investigative in nature. The point in the data collection where it became repetitive and no additional new information was being found was considered the time to finish data collection (Glaser & Strauss 1967).

4.1.8 Analysis

The interviews and focus group were transcribed by the researcher into semi-verbatim transcripts with the exception of five interviews which were transcribed verbatim by a transcribing service. The time to transcribe each semi-verbatim interview varied from 60 to 120 minutes. The analytical technique used to make sense of the interviews and the focus group was a thematic qualitative analysis. Explanations given by the respondents were related to predetermined themes and sub-themes relevant to the theoretical perspectives of the study and the research questions. The themes were:

1. Health Care Received in Prison.
 - Services Not Provided to Aboriginal Prisoners.
 - Desired Health Services and Programs in the New Prison.
2. Family Welfare.
3. Organizations Providing Programs on Release.
4. Culture and Tradition in Prison.

The report has been written using the respondents' unedited interview material to elicit the key points leading to the findings and recommendations.

4.1.9 Capacity Building and Team Approach to the Study

Winnunga is the only Aboriginal Community Controlled Health Service delivering holistic health services for Aboriginal people in the ACT and region. The study provided opportunities for capacity building (Eade 1997) and participatory action research (Wadsworth 2001). The participatory action research approach to health 'is based on reflection, data collection, and action that aims to improve health and reduce health inequities through involving the people who, in turn, take actions to improve their own health' (Baum et al. 2006). For this study it involved the Aboriginal Co-researchers participating in a one-day training session and the researcher subsequently working interactively with the Co-researchers. The Co-researchers' experience of the prison environment was first-hand and profound, and this resulted in knowledge and skills being transferred in both directions. This was particularly significant in developing the interview and focus group questions. Best practice knowledge transfer approaches were also used which took into account cross-cultural complexity, Aboriginal knowledge systems, and understandings. A one-day Workshop involving the study partners was used to reflect on the study findings and recommendations.

In the course of the study a further capacity building opportunity arose within the ACT community in providing information to the Nannies' Group (previously identified in the Focus Group Section) about acquiring a computer and a meeting place. The Co-researcher training received by The Connection representatives will provide future opportunities for further training or a CRCAH cadetship.

4.2 Limitations of the Study

There are no interviews with current Aboriginal prisoners. The time-frame and budget considerations of the study determined this approach and were also a consideration in the number of respondents included in the study. The administrative procedures of applying for and obtaining permission for admittance to male and female prisons was beyond the research study timeframe. While this approach may have been limited by not obtaining prisoners' immediate experiences while incarcerated, it would have been more restricted in the variety of respondent experiences of prison health. The approach which was used obtained a variety of perspectives from males and females across a wide age range, who were released from incarceration over



different timeframes, with different experiences of prison. It also included respondents awaiting reappearance in court, and sentencing for additional offences. Other limitations in the scope of the study included:

- The study does not examine health needs in Police custody;
- The study does not include juveniles (under the age of 18 years); and
- Several interviews were conducted in less than ideal circumstances because of the condition of the interviewees. These ex-prisoner respondents were under the influence of alcohol and/or drugs which may have affected the reliability of the data. However, this indicated the complexity of these respondents' lives. These interviews were completed to avoid an unnecessary burden on the respondent at another time.

Chapter Five - A NATIONAL VIEW OF ABORIGINAL HEALTH AND WELLBEING

Aboriginal Australians' life expectancy is about 17 years less than that of non-Aboriginal Australians. The relative socioeconomic disadvantage of Aboriginal people compared with non-Aboriginal people contributes towards an increased prevalence of a number of illnesses. These include circulatory diseases, diabetes, respiratory diseases, musculoskeletal conditions, kidney disease, eye and ear problems, and mental and behavioural disorders. Aboriginal Australians are at least twice as likely to need assistance with self-care, mobility and communication in daily living as non-Aboriginal people. They are at greater risk of exposure to behavioural and environmental health risk factors such as tobacco and drug and alcohol use, lack of physical activity, and life stressors such as physical or threatened violence. The stolen generations also have poorer health outcomes in comparison to those who were not removed from their families. Together with numerous health stressors, young Aboriginal people experience problems of identity.

5.1 Introduction

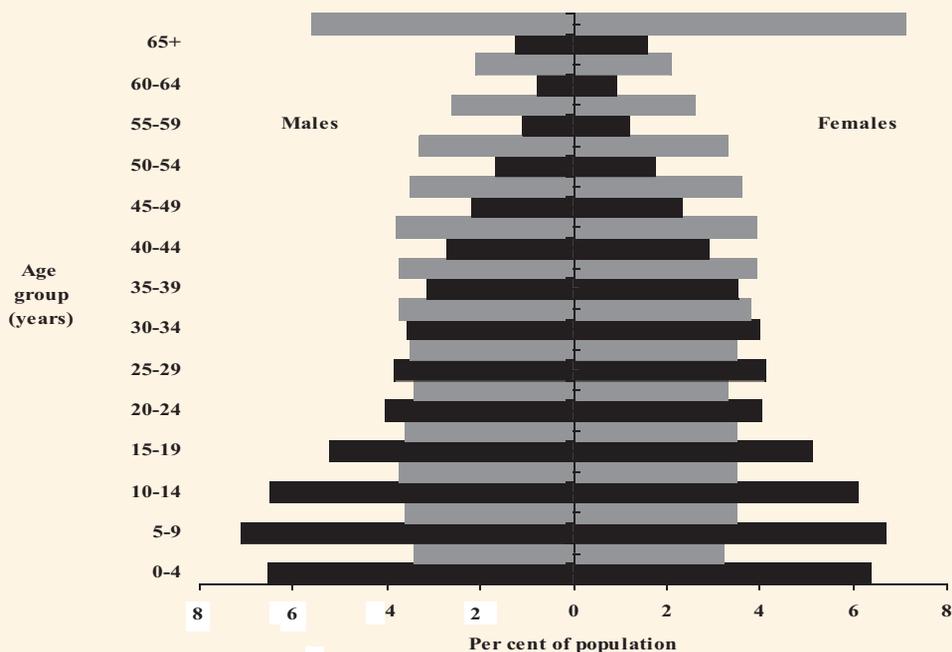
What are the health and cultural considerations attached to delivering holistic health care services for Aboriginal inmates in the ACT Alexander Maconochie Centre? (Research Question 1).

This chapter presents an Aboriginal population profile to provide an understanding of the overall poor health and wellbeing of Aboriginal people in the general community. This data has a bearing on the extent of health services Aboriginal inmates will require in the new ACT Prison due for completion mid 2008. How Aboriginal people view wellness and illness is in part based on cultural beliefs and values. At the service interface these perceptions and the social interaction surrounding them influence when and why Aboriginal communities access services. The RCIADIC (2001) recommended greater involvement of community-based Aboriginal Medical Services in the delivery of primary health care to Aboriginal people in Police custody and prisons due to their holistic health service delivery (examined in Chapter Seven).

5.2 Aboriginal and Torres Strait Islander Population

The Aboriginal population of Australia was estimated to be 458,500 people on 30 June 2001, representing 2.4 per cent of the total Australian population (ABS & AIHW 2005: 3). The Aboriginal population is relatively young, as shown in the population pyramid in Figure 5.2.1, with a median age of 21 years compared to 36 years for the non-Aboriginal population (ABS & AIHW 2005: 3).

Figure 5.2.1 The Aboriginal and Torres Strait Islander and Total Population of Australia in 2001, by age and sex*



* Data obtained from the Australian Bureau of Statistics (ABS) website <http://www.abs.gov.au>. [Black bars represent Aboriginal & Torres Strait Islander people and grey bars represent the total Australian population].

Aboriginal people suffer the poorest health of all Australians (ABS & AIHW 2005; AIHW 2006: 221-232). Aboriginal people remain disadvantaged, compared to other Australians across a range of areas of social concern. They continue to experience lower levels of employment, and higher levels of unemployment than non-Aboriginal people, with Aboriginal adults being more than twice as likely to be unemployed (13 per cent) as non-Aboriginal adults (5 per cent). The mean equalized gross household income of Aboriginal adults in 2002 was \$A394 per week, 59 per cent of non-Aboriginal adults' corresponding household income (\$A665 per week). Thirty (30) per cent of the Aboriginal population live in major cities, 43 per cent in regional areas and 26 per cent in remote areas. The majority of Aboriginal people live in NSW (29 per cent), Queensland (27 per cent), WA (14 per cent) and the NT (12 per cent). Aboriginal people comprise about 30 per cent of the NT population but less than 4 per cent in all other State/Territory populations (ABS & AIHW 2005: 3-16).

Aboriginal Australians are significantly over-represented in the prison system. Twenty-two (22) per cent (i.e. 5,578) of all adult prisoners in Australia on 30 June 2005 were Aboriginal (ABS 2005). They were imprisoned at a rate of 2,021 per 100,000 adult Aboriginal population compared with 125 per 100,000 non-Aboriginal adult population (AIHW 2006: 249).

5.3 Alexander Maconochie Centre

The ACT Alexander Maconochie Centre will open in mid 2008. At this time, Aboriginal people in the Belconnen and Symonston Remand Centres in the ACT and those sentenced to full-time custody by the ACT and held in NSW prisons will be transferred to the new Centre. They could number in the vicinity of 17 ACT remandees and nine prisoners, according to Australian Bureau of Statistics data (ABS, 2005: 13, 36). Some prisoners in the ACT Centre will not be residents of the ACT but will have been sentenced in ACT Courts. Conversely there will still be ACT residents imprisoned in NSW prisons. Transfers to prisons in the city of residence (under legislation on welfare grounds) are possible but can be a lengthy procedure (Interviewee 32, Senior Policy Officer, ACT Corrective Services, 22 November 2006). Overall the \$A113 million Centre will cater for up to 300 inmates (Corbell, Media Release 16 October, 2006). It will include a replacement ACT remand centre, a facility for sentenced prisoners, and a transitional release centre. The transitional release centre enables prisoners to establish support systems

in the community, family contacts, secure employment and re-adjustment to community life. The Centre will accommodate men and women of all security classifications. The design provides for single cell, double cell, and cottage style accommodation to respond to the needs of different prisoner requirements (Stanhope, Media Release 9 January 2004).

Prisoners suffer poor health and have a high rate of mental health and substance abuse problems, with women suffering from physical, mental and sexual abuse. It is the ACT Government's intention that the Centre's standard of health services will be at least equivalent to that available in the general community. For example, the principles of the Centre's general health model include minimizing self-harm, reducing dependency on drugs, treating mental health problems, and promoting a healthy lifestyle in prison and on release into the community. Throughcare principles will be utilized in the medical centre in providing initial health assessments, treatment, consultations and clinical support for primary health needs. More complex assessments, consultations and surgery will be carried out by the local hospitals. The design of the Centre allows for women's special needs in their cottage style accommodation, with provision of accommodation for their children (Stanhope, Media Release 9 January 2004). A Masterplan for the Centre can be obtained at: http://www.cs.act.gov.au/_data/assets/pdf_files/27407/Masterplan_colour_.pdf [Accessed 21 April 2007].

The ACT Health, Draft ACT Corrections Health Service Plan 2006-2009 (ACTG 2006b) devotes special attention to the gender specific health needs of women within the social context of their lives; and the health needs of Aboriginal people. It also gives consideration to the possibility of engaging Winnunga or another appropriate service to deliver a dedicated Aboriginal health service to Aboriginal prisoners in the new prison. An examination of the health and well-being of Aboriginal Australians follows.

5.4 Aboriginal and Torres Strait Islander Health and Wellbeing

Access to education, employment and housing over time are significant factors contributing to the poor health and welfare of Aboriginal Australians (ABS & AIHW 2005: 3-16). Aboriginal Australians are twice as likely to report their health as fair or poor as non-Aboriginal Australians. These reportings are higher for those in the lowest income quintile (20 per cent) for equalized household income, for those who are unemployed or not in the labour force,

and for those whose highest year of school completed is Year 9 or below (ABS & AIHW 2005: 91-132).

The conditions that account for most of the consultations by Aboriginal people with general practitioners, and are the main reasons for hospitalization, are circulatory diseases, diabetes, respiratory diseases, musculoskeletal conditions, kidney disease, eye and ear problems and mental and behavioural disorders. Aboriginal Australians are hospitalized for diabetes at five times the rate of other Australians, twelve times higher for care involving dialysis, and twice the rate for respiratory diseases and injury. They are at least twice as likely to need assistance with self-care, mobility and communication in daily living as non-Aboriginal people (ABS & AIHW 2005: 179-206).

Health risk factors for Aboriginal Australians include their relative socioeconomic disadvantage compared with non-Aboriginal people (ABS & AIHW 2005: 133-146). This places them at greater risk of exposure to behavioural and environmental health risk factors such as tobacco, drug, and alcohol use, lack of physical activity, and life stressors such as physical or threatened violence. The stolen generations also have poorer health outcomes in comparison to those who were not removed from their families. The House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs (HRSCATSIA 2001: 40-92) found young Aboriginal people face the problems of:

Substance abuse, emotional and physical abuse, poor school attendance, low levels of education, high unemployment with poor job prospects, difficulties finding accommodation, lack of parental involvement or control, poverty, and being young single parents with poor parenting skills.

These stressors occur where mainstream culture is dominant; when establishing their identity as Aboriginal people, whilst balancing their involvement in the Aboriginal and mainstream community; and in facing the challenges for young people coming to terms with who they are. Aboriginal youth were described by the HRSCATSIA (2001: 74) as being an apocalyptic generation who do not envisage a future having a sizeable minority with no apparent social norms, and a deep-seated hostility to white society.



Babies with an Aboriginal mother are twice as likely to be low birthweight (<2,500 grams) compared to babies with a non-Aboriginal mother. The mortality rate for Aboriginal infants is three times more than for non-Aboriginal infants, and more than twice for Aboriginal children aged 1-14 years compared to non-Aboriginal children of the same age (ABS & AIHW 2005: 73-90).

Life expectancy at birth for Aboriginal Australians in the period 1996-2001 was estimated to be 59.4 years for males and 64.8 years for females, compared with 76.6 years for all males and 82.0 years for all females for the period 1998-2000, a difference of approximately 17 years for both males and females (ABS & AIHW 2005: 148). A recent policy briefing paper reinforces the poor health outcomes of Aboriginal Australians (OA & NACCHO 2007).

Chapter Six - A NATIONAL VIEW OF ABORIGINAL PRISONER HEALTH AND WELLBEING

Aboriginal people are incarcerated at 12 times the rate of non-Aboriginal people. Seventy-nine (79) per cent of Aboriginal prisoners are aged between 20 and 39 years. The average length of imprisonment is 4.8 months. Offences include: offensive behaviour and against good order offences, assault, driving and property-related offences, breach of bonds, and contempt of court. All governments have supported the RCIADIC recommendations regarding alternatives to imprisonment and diversion from Police custody. However a low rate of summons, bail refusal and sentencing of Aboriginal people pertains. Other recommendations have been taken up by Governments in varying degrees. The Aboriginal imprisonment rate has increased since the RCIADIC Report in 1991. The rates of death among Aboriginal prisoners (1990-2004) reflect their greater vulnerability in self harm, and poor health due to not accessing health services prior to incarceration. There is a need for culturally sensitive health programs that target early detection of chronic diseases and health promotion activities in prisons. Many Aboriginal drug injectors use drugs for the first time in prison. Drug harm minimization strategies and screening strategies for blood-borne viruses, and sexually transmitted infections are of paramount importance in custodial health.

6.1 Introduction

The findings and recommendations of the RCIADIC form a template for appropriate health and wellbeing for Aboriginal people in the criminal justice system. The rate of incarceration of Aboriginal people is about 12 times more than non-Aboriginal people. The custodial demography contained in this chapter presents a snapshot of Aboriginal people in prison throughout Australia on 30 June 2005, and through a broader view of custodial demography for the March 2006 quarter. It also examines the most common types of criminal behaviour which result in Aboriginal people being incarcerated. This examination of Aboriginal people in prison provides a basis from which to examine prisoners' health issues such as custodial mortality, morbidity, and the custodial risk factors.

6.2 Royal Commission into Aboriginal Deaths in Custody

The RCIADIC was a joint undertaking by the Commonwealth, the States and the Northern Territory. It was in response to concern that deaths in custody of Aboriginal people happened too often and public explanations were not credible. The RCIADIC investigated 99 deaths of Aboriginal people while in the custody of Police, prison or juvenile detention institutions between 1 January 1980 and 31 May 1989. It examined the circumstances of the deaths and the underlying causes such as social, cultural and legal issues. The RCIADIC's final report of April 1991 provided the following profile of the lives of the 99 people (Commonwealth and State Ministers 1992: 4):

- They were young, the average age at death being thirty-two;
- Only two had completed secondary schooling;
- 83 were unemployed at the date of last detention;
- 43 had been separated as children from their natural families;
- 74 had been charged with an offence before the age of nineteen;
- 43 had been taken into custody for an alcohol-related offence; and
- The standard of health of the 99 varied from poor to very poor.

The RCIADIC found that Aboriginal people are grossly over-represented in custody. This is the reason for the unacceptable number of deaths in custody, the most contributing factor being the disadvantaged and unequal position of Aboriginal people socially, economically and culturally in Australian society. The Ministers of the Joint Ministerial Forum on the RCIADIC agreed with the majority of the 339 recommendations. They fully accepted the RCIADIC's recommendations that the problem be tackled simultaneously on two levels (Commonwealth and State Ministers 1992: 1). These were:

1. at the level of improvement to Aboriginal people's position regarding the criminal justice system; and
2. strengthening the commitment to redress the factors that bring Aboriginal people into contact with the criminal justice system.

6.3 Criminal Justice System

Some examples of these recommendations involving the criminal justice system are:

- establishing community policing and community justice programs at the local level;
- establishing Aboriginal Justice Committees in each State and Territory as a means of obtaining Aboriginal views on criminal justice issues; and
- Aboriginal people to be included in developing protocols on coronial, policing and custodial issues.

Due to the historical legacy of distrust of justice systems, the RCIADIC emphasized the importance of cross cultural training for court officers and prison staff and positive interaction between administrators and Aboriginal people. It also considered that similar cross cultural training should apply to the issues of Police conduct and complaints adjudication, as well recruiting Aboriginal people, and training for better understanding of Aboriginal people in society (Commonwealth and State Ministers 1992: 11-18).

Following the RCIADIC all Governments supported imprisonment as a last resort. However, the RCIADIC noted that alternatives to imprisonment needed to be backed up by expunging criminal records, using community service orders, amnesty on executing long outstanding warrants for unpaid fines, and removing imprisonment as an automatic consequence of fine default. There was support for these recommendations with the exception of home detention because of concerns about domestic violence which could lead to custody. Additionally, all governments supported recommendations which focused on diversion from Police custody. These included decriminalization of drunkenness, non-custodial facilities developed to care and treat intoxicated people and Police arrest a sanction of last resort (Commonwealth and State Ministers 1992: 11-18).

All States and Territories have enacted anti-discrimination legislation relevant to discrimination and mistreatment. The Optional Protocol of the International Covenant on Civil and Political Rights also enables people to make a complaint to the United Nations' Human Rights Committee should they not succeed through domestic channels. All Governments also supported recommendations to give the Coroner greater control of, and responsibility

to ensure that Police investigations are adequate, and for additional funding for Aboriginal Legal Services. In addition, the RCIADIC made more than 60 recommendations about improving custodial conditions and practices. They included up-grading cell conditions in all jurisdictions, improvement of Police and prison officer procedures and training, health, risk assessment and safety procedures, and the greater use of prisoner visitor schemes (Commonwealth and State Ministers, 1992: 11-18). Since the 1991 RCIADIC Report when the imprisonment rate for the Aboriginal population was 1,122.1 per 100,000 adult Aboriginal population (Carcach et al. 1999), the rate has increased to 2,021 per 100,000 adult Aboriginal population (AIHW 2006: 249).

6.4 Custodial Demography - A National Picture of Indigenous Persons in Prison on the Night of 30 June 2005

The ABS National Prisoner Census recorded prisoners in the legal custody of adult corrective services in adult prisons, including periodic detainees in NSW and the ACT, on the night of 30 June 2005 (ABS 2005). It showed that the number of Aboriginal prisoners in Australia increased by 12 per cent from 5,048 at 30 June 2004 to 5,656 at 30 June 2005 – the greatest annual increase since 1999. These statistics do not represent the flow of prisoners during the year. However, they record that Aboriginal prisoners represented 22 per cent of the total prisoner population at 30 June 2005 (the highest since 1995). The NT and Tasmania had the highest proportional increases over the year (both 19 per cent). The NT prisoner population rose from 556 at 30 June 2004 to 663 at 30 June 2005, and 59 to 70 for the same period for Tasmania. Victoria was next with an 18 per cent increase, rising from 186 prisoners to 220. In the NT 81 per cent of the prisoner population was Aboriginal while Victoria had the lowest proportion of 6 per cent (ABS 2005: 5).

When comparing the rates of imprisonment for Aboriginal and non-Aboriginal prisoners held in Australian prisons, the ABS age standardized rate of imprisonment for Aboriginal prisoners was 1,561 per 100,000 adult Aboriginal population, making Aboriginal persons 12 times more likely than non-Aboriginal persons to be in prison at 30 June 2005. WA and SA recorded the highest age standardized ratios of Aboriginal to non-Aboriginal rates of imprisonment with Aboriginal persons being 19 and 13 times respectively more likely to be in prison. Tasmania had the lowest rates with Aboriginal persons being four times more likely to be in prison. Regarding the age of Aboriginal prisoners throughout Australia, the majority (79 per cent) of

Aboriginal prisoners were aged between 20 to 39 years, while just over two thirds (68 per cent) of the non-Aboriginal population were in this age group. The median age of Aboriginal and non-Aboriginal prisoners was 30 and 33 years respectively (ABS 2005: 5, 8). The custodial demography in the following section presents a snapshot of Aboriginal people in prison throughout Australia on 30 June 2005 and provides a broader view of custodial demography for the March 2006 quarter.

6.5 Custodial Demography - A National Picture of Indigenous Persons in Prison for the March 2006 Quarter

Of the 5,842 Aboriginal adult prisoners in full-time custody in Australia for the March 2006 quarter (issued 22 June 2006), 5,377 (92 per cent) were males and 465 (8 per cent) were females. Almost 80 per cent of the total Aboriginal prisoner population was located in NSW (1,823 persons); Queensland (1,450 persons); and WA (1,351 persons). The national rate of imprisonment for Aboriginal persons in the March quarter 2006 was 2,035 per 100,000 adult Aboriginal population, an increase of 2 per cent since the March quarter 2005 and an increase of 1 per cent since the previous quarter (ABS 2006: 4-5). This compares with 125 per 100,000 adult population among non-Aboriginal persons (AIHW 2006: 249).

The highest rate of imprisonment of Aboriginal persons was recorded in WA (3,268 Aboriginal prisoners per 100,000 adult Aboriginal population), followed by NSW (2,239). The largest proportional increases in the rate of imprisonment of Aboriginal persons since the March quarter 2005 were recorded in Victoria and Queensland (both 10 per cent). The next highest increase (5 per cent) was in the ACT (including ACT prisoners held in NSW prisons) (ABS 2006: 4-5).

On a national level the majority (79 per cent) of Aboriginal prisoners were aged between 20 to 39, while just over two thirds (68 per cent) of the non-Aboriginal population were in this age group. The median age of Aboriginal and non-Aboriginal prisoners differed (30 years and 33 years respectively). Just under a third (29 per cent) of all Aboriginal prisoners were sentenced for acts intended to cause injury. This offence accounted for 11 per cent of all non-Aboriginal sentenced prisoners. Aboriginal sentenced prisoners comprised 3 per cent of the total number of sentenced prisoners with an offence of illicit drugs (ABS 2006: 8).

Aboriginal unsentenced prisoners were more likely to be on remand for acts intended to cause injury (45 per cent) than non-Aboriginal unsentenced prisoners (21 per cent). Aboriginal unsentenced prisoners were less likely to be on remand for charges of homicide and related offences (7 per cent of Aboriginal remandees, 11 per cent of non-Aboriginal remandees) and illicit drug offences (2 per cent of Aboriginal remandees, 10 per cent non-Aboriginal remandees). The median time spent on remand by Aboriginal prisoners at 30 June 2005 was 1.9 months, less than that spent on remand by non-Aboriginal prisoners (3.1 months). The median time on remand by Aboriginal prisoners was less than non-Aboriginal prisoners for almost all charge types except sexual assault, and related offences and robbery, extortion and related offences, where the median time on remand was the same for Aboriginal and non-Aboriginal prisoners (4 months and 3.6 months respectively) (ABS 2006: 10).

6.6 Nature of Aboriginal Crime

Drawing on NSW Bureau of Crime Statistics and Research unpublished data, Cunneen (2002) provides an indication of the Aboriginal justice situation in the NSW local courts where the majority of criminal matters are dealt with. The greatest proportion of offences relate to road traffic and motor vehicle offences (one in four are attributed to Aboriginal people; four in 10 for non-Aboriginal people). Aboriginal people have a much greater proportion of assault, public order offences, property damage and offences against justice procedures.

Aboriginal people in NSW are vastly over-represented in prosecutions for offensive language and behaviour. Research by the Aboriginal Justice Advisory Council (NSWAJAC 1999) found that Aboriginal people were involved in 20 per cent of all prosecutions for these offences. Fourteen (14) per cent of all Aboriginal people appearing in NSW Local Courts had previously been charged for offensive language or offensive conduct.

On a national level, Aboriginal prisoners comprise a low proportion convicted of white-collar offences and other premeditated forms of crime including murder. They are also relatively under-represented in fraud and misappropriation, drug-related offences, extortion, prostitution and environmental offences. They are most likely to be in prison for offensive behaviour and against good order offences, assault, driving and property-related offences, and justice

procedures offences (i.e. contempt of court and breach of bonds). Alcohol-related violence is a significant feature in the crimes of homicide and violent assault (Hazelhurst & Dunn 1988). Hunter (2001) found that drink-related offences comprise in excess of 50 per cent of Aboriginal arrest rates.

6.7 Type of Intervention

There are a variety of options that Police can employ when they suspect a criminal offence has occurred. These include a warning, arrest and charges, a summons or court attendance notice, or a field court attendance notice. Many legal and non-legal reasons influence their use of discretion in these matters including the type of offence, if the person has admitted the offence, if they received legal advice, and their prior record. The low rate of summons use has been of concern, particularly for public order offences. Another area of concern is bail refusal and unrealistic conditions attached to bail. Research by the NSW Aboriginal Justice Advisory Council (NSWAJAC 2002) found that Aboriginal people were less likely to receive bail than non-Aboriginal Australians. When bail was granted the conditions were often unrealistic or difficult to accept and breaches occurred at a high rate. Forty five (45) per cent of Aboriginal people who were refused bail did not receive a custodial sentence.

There is little difference in the average length of imprisonment for Aboriginal people and the general population (4.8 months compared to 4.9 months). However in all offence categories where Aboriginality was recorded, a greater proportion of Aboriginal people received a sentence of imprisonment than non-Aboriginal people. There is a larger proportion of Aboriginal people in prison than non-Aboriginal people who have been previously incarcerated. Cunneen (2002: 25) suggests that the Aboriginal community generated alternatives to prison (such as community corrections) particularly for those sentenced to six month imprisonment or less could provide solutions.

6.8 Aboriginal Prisoner Health

The further issue identified by the RCIADIC was Aboriginal health which it considered must be addressed because of its connection to the disproportionate number of Aboriginal people in custody. The RCIADIC found a clear relationship between the continuing poor health status of Aboriginal people and their deaths in custody. It noted that the high rates of illness, self destructive

behaviour, crime and violence all related to the disadvantage experienced by Aboriginal people.

Of the 99 deaths in custody the RCIADIC investigated, alcohol and drug abuse was a prominent feature. Public drunkenness was classified as the most serious offence leading to detention in 27 cases. Nine deaths were associated with dangerous alcohol and drug use, 37 were due to disease (including 19 from pre-existing heart disease and 7 from respiratory disease). The RCIADIC identified a mismatch between available health services and the needs of Aboriginal people (Commonwealth and State Ministers 1992: 46). Consequently its recommendations addressed:

- More immediate life-style problems, particularly alcohol and substance abuse, which have a direct relationship with the incarceration of Aboriginal people; and
- Longer term problems associated with the underlying social disadvantage experienced by Aboriginal people, and evidenced by their poor health and reduced life expectancies.

Other recommendations relating to Aboriginal health included a National Aboriginal Health Strategy with additional resources for Aboriginal Health Services for health promotion and awareness, counseling, and outreach health services for young people (addressing homelessness violence, prevention of HIV/AIDS); recognition of the need for Aboriginal designed, controlled and staffed drug and alcohol services and substance abuse programs; more extensive health measurement and resultant data through the Council for Aboriginal Health and Tripartite Forums; training programs for Aboriginal and non-Aboriginal Health Workers; Aboriginal involvement in decision making through the Council for Aboriginal Health and Tripartite Forums; evaluation of Aboriginal Community Controlled Health Services; expansion of Aboriginal mental health services; increase in Aboriginal research into health concerns identified by Aboriginal health advisory bodies; Aboriginal involvement in health promotion strategies targeted at Aboriginal people – for example Drug Offensive media campaigns (Commonwealth and State Ministers, 1992: 45-49). These initiatives have been promulgated nationally in varying degrees.

6.9 Aboriginal Prisoner Health – Females

The RCIADIC noted that Aboriginal women have been imprisoned and have died in custody. Chapter Seven provides a detailed examination of the health of Aboriginal women in prison. Aboriginal women suffer bereavement as wives and mothers. They also bear the burden of the community's stress, grief, despair and alienation. Women teach many of the laws and ceremonies. They are the custodians of the culture, artifacts, skills and certain land and are affected by dwindling communities because of high levels of imprisonment, and the deaths of many young people from violence, poverty and deprivation. They are also victims of violence in communities and many die young from diseases. They carry the main responsibility for nurturing the children and keeping the family together when a family member is in prison (see Aboriginal family perspectives in Chapter Ten). Consequently the RCIADIC considered that Aboriginal women should be appropriately involved in developing and delivering government and community-based programs. These would include programs such as community development under CDEP programs, alcohol and substance abuse programs and education, and economic equality initiatives. These initiatives have also been taken up nationally in varying degrees (Commonwealth and State Ministers, 1992: 45-49).

6.10 Custodial Mortality

Recommendation 150 of the RCIADIC states that health care to persons in prisons should be an equivalent standard to standards available to the general public. This care should include medical, dental, mental health, drug and alcohol services provided in the prisons or made available through community facilities and services. Prisons should employ sufficient qualified and competent personnel who are accessible and appropriate to Aboriginal prisoners. There should be a 24 hour a day service by medical practitioners and nursing staff either on the premises or on call (RCIADIC 1991a).

In researching custodial mortality of Aboriginal people in prisons Wenitong & Daniels (2003: 610) found that almost three times as many Aboriginal people died in prisons in the ten years following the RCIADIC as died in the previous decade studied in the report. This was due to the incarceration of Aboriginal people doubling in that time and the high prevalence of death in custodial settings. They concluded that the increasing numbers of deaths from suicide highlighted the importance of investigating the provision of mental

health services in prisons, providing cross cultural training for prison health staff in assessing suicidal ideation, and considering social and emotional issues for incarcerated Aboriginal people. They also suggested that adequate and culturally appropriate counseling and screening and specialist psychiatric services be provided.

Jouido's (2006: 1-6) research paper on deaths in custody in Australia from 1990-2004 concluded that although the majority of deaths in custody occurred in Police custody between 1980 and 1989, the trend in the 15 years since the RCIADIC reveals a different picture. Prison custody deaths account for the majority of deaths in custody since 1990 and have exceeded all other deaths each year. Of the 772 prison deaths since 1990, almost 19 per cent were Aboriginal prisoners. The causes of death were hanging (44.1 per cent); natural causes (45.5 per cent); external/multiple trauma (4.8 per cent); and drugs/alcohol (4.1 per cent). While the number of deaths of non-Aboriginal prisoners consistently exceeded deaths of Aboriginal prisoners, the rate of Aboriginal prisoner deaths exceeded the rate of non-Aboriginal prisoner deaths in 8 of the 15 years since the RCIADIC, reflecting the general over-representation of Aboriginal people in prison. Jouido concluded that the rates of death among Aboriginal prisoners reflect their greater vulnerability in self harm, and poor health due to not accessing health services for treatment of long term health problems prior to incarceration. He also found that while deaths in Police custody have decreased since 1990, deaths in Police custody-related operations (such as motor vehicle pursuits) have been increasing. Wenitong & Daniels (2003) draw similar conclusions about custodial morbidity.

6.11 Custodial Morbidity

Wenitong & Daniels' (2003) examination of the NSW Inmate Health Survey 1996 found little available data on the incidence and prevalence of cardiovascular diseases, diabetes, respiratory diseases, or psychiatric illness in Aboriginal inmates. Psychiatric illness (particularly depression) together with drug and alcohol-related effects were reported to be the most common causes of ill health in prisons. In examining the causes of death of inmates from 1980 to 1989 they found approximately half of the deaths in custody were from suicide, with diseases of the circulatory system, injuries and diseases of the respiratory system the next most frequent cause of death. They concluded (Wenitong & Daniels 2003: 610) that the mean age at death of the Aboriginal prison population of 30.3 years necessitated:

the need for culturally sensitive health programs that target early detection of chronic diseases and health promotion activities in prisons. This means specific programs for physical, social, and emotional wellness as well as, for example, those for diabetes, heart disease, smoking cessation, and sexual health. General clinics and reactive medicine do not constitute an adequate response.

Levy's (1999) paper about developing a comprehensive Aboriginal Health Strategy for the New South Wales Corrections Health Service involving Aboriginal Medical Services also highlighted various concerns for Aboriginal inmates' health. The paper found that:

- Aboriginal inmates were twice as likely to have been exposed to the germs of the tuberculosis family than non-Aborigines;
- 18 per cent of Aboriginal males were hepatitis C antibody positive compared with 29 per cent of non-Aboriginal males;
- 45 per cent of Aboriginal females were hepatitis C positive, similar to non-Aboriginal females; and
- 57 per cent of Aboriginal males identified that they drank alcohol at a harmful level compared with 29 per cent of non-Aboriginal males.

Levy identified the key health needs of Aboriginal inmates as primary health care services for diabetes; circulatory system disease; women's health including sexual health; genital tract screening; maternal and child health; public health including sexual health (including HIV) and immunization; mental health services; alcohol and other drug rehabilitation services; and oral health services.

Levy (1999) noted however, that Aboriginal inmates access clinics less than non-Aboriginal inmates (i.e. Aboriginal males and females 34 per cent and 48 per cent respectively, compared with non-Aboriginal males and females 48 per cent and 64 per cent respectively). However, the 2001 NSW Inmate Health Survey recorded that satisfaction with the Aboriginal Health Services was high among 75 per cent of females and 87 per cent of males (Butler & Milner 2003: 57).

6.12 Recognizing and Redressing Custodial Risk Factors

Wenitong & Daniels (2003) found that the high rates of blood-borne virus infections in prison suggested that inmates were already infected prior to entering prison through risk-taking behaviour, or acquired the infection while in prison. However, they were unable to ascertain the proportion of the prison population acquiring infections for the first time while in prison. Wenitong & Daniels found that many Aboriginal injectors used drugs for the first time in prison; that Aboriginal injecting drug users have higher rates of sharing injecting equipment than non-Aboriginal injectors; and injecting drug use and unsafe practices such as sharing and re-use of syringes is widespread in prisons. Tattooing among Aboriginal inmates is also widespread. Regarding the risk of spreading blood-borne infections, they found that sharing equipment and interpersonal violence increased this risk, as well as Aboriginal men sharing ceremonial instruments in community ceremonies on release from prison. They found that there was little data on sexual activity within prisons, including forced sexual activity, attitudes of Aboriginal people in prison to male-to-male sex, and best practice for harm minimization strategies (Wenitong & Daniels 2003).

Wenitong & Daniels (2003) have highlighted the urgent need to raise the standards of prison health care to a level available to the general population. They consider that engaging more Aboriginal Community Controlled Health Services through partnership arrangements with prison health services, to deliver services to Aboriginal people in prisons will result in substantial improvements in their health. Wenitong & Daniels (2003) suggest the following strategies to improve custodial health:

- harm minimization strategies including making clean needles and syringes available; and appropriate methods of withdrawal from illicit drugs and alcohol addiction while in prison (noting that methods vary and continue to be a source of controversy);
- screening strategies for sexually transmitted infections and blood-borne viruses to include continuing intermittent screening and screening prior to discharge; pre-and post-test counseling; and effective follow-up with Aboriginal communities and health organizations for treatment on release. Screening strategies should also include comprehensive assessment for chronic disease. Prison is an opportunistic time to treat

such diseases in prison for a group of people who may not always access health services outside of prison;

- Confidentiality of personal medical information is important in prisons;
- All patients/prisoners should be considered to be potentially infectious when physical contact is necessary by medical or prison officer staff to protect their safety;
- A culturally sensitive health service is important in gender-based health services, particularly for remote and traditional Aboriginal prisoners. Practitioners of the same gender as the client is also important and health promotion materials must be developed with Aboriginal communities to take account of any sensitivity relating to women's or men's business;
- There is a lack of follow-up of health care on prisoners' release. Communication between prison, external health care agencies and Aboriginal Health Services is important. This involves developing good organizational relationships and systematic discharge planning by the Corrections health service providers; and
- Research is required into DNA applicability in Aboriginal populations due to the possible inability to distinguish close relatives with the degree of certainty required to secure a conviction.

The findings and recommendations of the RCIADIC, together with those who write from Aboriginal medical and justice health perspectives contribute to this study's development of the Winnunga Holistic Health Care Prison Model in the following chapters.



Chapter Seven – Australian and Overseas Perspectives of Aboriginal Prison Health

The RCIADIC found that Aboriginal Medical Services (AMS) provide a very valuable contribution to the care of Aboriginal prisoners with Aboriginal Health Workers playing a particularly important role, apart from doctors and other professionals. Winnunga currently provides this quality of health services to two NSW prisons and ACT remand centres. However, some inadequacies for ACT inmates of the NSW prisons include long waiting times for consultations. The AMSs in the states deliver services to prisons in varying degrees. Some AMS prison health services have been discontinued due to difficulties in arranging professional indemnity with prison authorities, and lack of AMS resources. Substance abuse, mental health, communicable diseases, and women's health are prominent in prison health needs. Prisoners in Australia are excluded from Medicare which impacts on access to tertiary care and seeking second opinions. Comparisons between Australian and overseas practices indicate similar needs for diversionary measures for those with mental health problems; treating substance abuse as a health issue as opposed to a law-enforcement matter; and a harm reduction approach to drug injecting in prisons including prison needle and syringe programs. Early intervention with Aboriginal women (regarding lack of education and employment) and treatment for sexual and physical abuse, mental health and alcohol and drug abuse problems may reduce contact with the criminal justice system.

7.1 Introduction

This chapter examines existing culturally sensitive prison health services. It presents a case study of Winnunga focusing on the current health services it delivers to the Goulburn and Cooma Prisons in NSW, and the Belconnen and Symonston Remand Centres in the ACT. It also focuses on the health services delivered by Aboriginal Health Services in other Australian jurisdictions. Additionally, this chapter examines the particular health requirements for Aboriginal Australians in prison for substance abuse, mental health, communicable diseases and women's health. It draws on overseas experience of Aboriginal people's health in prison, as well as mainstream prison populations in Europe, UK, Canada and the USA.

7.2 Aboriginal Medical Services in Prisons

The RCIADIC found that AMSs provide a very valuable contribution to the care of Aboriginal prisoners, with Aboriginal Health Workers playing a particularly important role apart from the doctors and other professionals. Submissions to the RCIADIC suggested greater involvement of community based AMSs in the delivery of primary health care to Aboriginal people in Police custody and prisons. This was supported by the RCIADIC due to the particular AMS knowledge and experience of endemic Aboriginal health problems and better skills in communication. Another reason for greater use of their expertise was due to Aboriginal people's under utilization of prison medical services, and their tendency not to make complaints about their health or actively seek out medical assistance. The RCIADIC found that although the authorities responsible for the delivery of prison health services were interested in increased AMS involvement, this did not eventuate due to lack of sufficient AMS resources. It recommended that sufficient resources be provided to AMSs so they can play an active role in delivering medical and health care, including health education programs and drug and alcohol counseling. In addition, the RCIADIC stressed the importance of more formal relationships between AMSs and prison authorities in recognition of their valuable input in delivering prisoner health care (Reconciliation and Social Justice Library, 1996).

In July 2005 the Australian Health Ministers' Advisory Council (AHMAC) Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) Working Group released two draft documents (SCATSIH 2005a,b) on:

- Guidance on Operational Standards for the Provision of Health Services to Aboriginal and Torres Strait Islander People in Custody; and
- Policy Guidelines for the Provision of Health Services to Aboriginal and Torres Strait Islander People in Custody.

These documents also highlighted the importance of involving Aboriginal community controlled health services and community organizations in prison health programs. They recognized the RCIADIC findings on the need to improve provision of health service to Aboriginal prisoners and increase their accessibility and appropriateness. In summarizing, they considered that

access to comprehensive prison health care and health promotion services and programs are important in improving and maintaining health and wellbeing. SCATSIH recognized that prisoners have very high health needs and their time in prison could be used to improve their health prior to reintegrating into the community. For these reasons they recommended (SCATSIH 2005a):

- Aboriginal specific services should complement mainstream health services with access to traditional healing where appropriate, thereby ensuring services equal to those in the general community; and
- The prison risk assessment and management processes for self-harming behaviour (coming into custody, throughout prison life and on release), should incorporate partnership arrangements between the health and correctional authorities with appropriate sharing of information between jurisdictions.

On the issue of independent monitoring, SCATSIH found that while most states and territories have internal audit or monitoring units, only WA and Victoria have an inspectorate. The Western Australian Custodial Inspectorate is the only state which has statutory autonomy and direct access to the Parliament. SCATSIH considered that the significant areas for monitoring were best practice in assessment, health care planning, and coordination.

Many Australian Aboriginal men and women enter the prison system with chronic health problems and complex needs because of the prevalence of disease in Aboriginal communities and the relatively poorer access to community health services. There is reduced capacity for prisoners to self-manage minor injuries or ailments with the assistance of families within the prison environment (SCATSIH 2005a). Prisoners in Australia are excluded from Medicare which impacts on access to tertiary care and seeking second opinions (Levy 2005). Consequently, SCATSIH advocated best practice models which encourage a triage-based screening process to identify immediate health needs or significant health concerns on reception at the prison which are further assessed using evidence-based protocols. A second general health assessment would follow within a week of reception, thereby completing the assessment of the prisoner's health status. This is a significant opportunity for raising awareness in health care and coordination of health services for Aboriginal prisoners whether on long or short term imprisonment (SCATSIH 2005a). In the following section a case-study of Winnunga provides some

insight into the prison health service currently available to the ACT Aboriginal community incarcerated in NSW prisons and ACT remand centres. Other Aboriginal Medical Services provide services in their jurisdictions to varying degrees as described in the following sections.

7.3 Winnunga Nimmityjah Aboriginal Prison Health Service Case-Study

For the past eight years Winnunga Nimmityjah Aboriginal Health Service, located in the suburb of Narrabundah in the ACT, has provided health services to Aboriginal prisoners in the NSW prison system and the remand centres in the ACT. Currently Winnunga's Medical Director visits the Belconnen Remand Centre (BRC). He has a clinic for Aboriginal and non-Aboriginal remandees once a week. In addition, the Winnunga Aboriginal Health Workers and the Psychiatrist visit the BRC independently when required for social and emotional wellbeing counseling and mental health care. A medical service is also provided for Aboriginal youth detained at Quamby Juvenile Detention Centre on an as required basis. The Winnunga Medical Director and an Aboriginal Health Worker visit Goulburn Prison in NSW once a fortnight and Cooma Prison in NSW once a month. The Aboriginal Health Worker provides the opportunity for prisoners to talk and receive social and emotional wellbeing counseling during the clinical consultations (Winnunga Medical Director Interviewee 22, June, November 2006).

These prison health services have been contracted by NSW Justice Health and ACT Health. This model ensures clients have access to culturally appropriate care and support for themselves and their families while in the corrective services system. It also provides a link to Winnunga and other support services, if required on release. In the area of prison health care service Winnunga is at the forefront in delivering health services to Aboriginal prisoners. The knowledge gained in providing health services to Aboriginal inmates and remandees has highlighted the importance of improving the current inadequate health service delivery model in the ACT. Some of the inadequacies include (Winnunga Medical Director, Interviewee 22, June, November 2006):

- The waiting time for prisoners to see the Winnunga Doctor at Goulburn Prison can be 6 to 8 weeks. This is due to short consultation periods and the large number of Aboriginal patients. The service is available to all Aboriginal prisoners in the prison;

- There is not sufficient time for the Aboriginal Health Workers to communicate with prison health staff and the Aboriginal Liaison Officers about the prisoners' welfare; and
- Some Aboriginal prisoners are located in prisons too distant to deliver Winnunga's prison health service.

Winnunga is a primary health care service initiated and managed by the local Aboriginal community to provide a culturally safe holistic health service to the Aboriginal people of the ACT and surrounding areas. The service is governed by a Board whose members are drawn from the local Aboriginal community and elected by the membership. In Wiradjuri language, Winnunga Nimmityjah means *Strong Health*. The service logo is the Corroboree Frog that is Indigenous and significant to the Aboriginal people in the ACT region. The holistic model of health care provided by Winnunga encompasses not only medical care, but a range of programs to promote good health and healthy lifestyles. Winnunga (2005) undertakes:

- To provide a culturally appropriate medical service for the Aboriginal people in the ACT and region;
- To promote a holistic approach to good health and healthy lifestyles in a culturally safe environment;
- To ensure that the health needs (healthy lifestyle, healthy body, social and emotional health, cultural and spiritual health, and economic circumstances) of Aboriginal people in the ACT and region are being addressed in a culturally safe and friendly environment; and
- To network and liaise throughout the ACT and region with other Aboriginal organizations, non-government organizations/agencies and other mainstream services, as well as ACT and Commonwealth government departments that have an interest in health and related matters. This is to ensure better delivery of services to the ACT and region's Aboriginal peoples.

This holistic approach provides the support families require while a family member is incarcerated and helps ex-prisoners reintegrate into the family and the community on release. For example, Winnunga operates medical, dental and psychotherapist/psychologist clinics. In line with the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (2004-2009) (AHMAC 2004), Winnunga also employs a multi-skilled social Aboriginal Health Worker team consisting

of Aboriginal social and emotional wellbeing counselors, alcohol and other drugs workers and youth workers. In addition, the day-to-day operations of Winnunga also include advocacy for:

- the homeless and mentally ill;
- clients whose holistic needs encompass housing, Centrelink, Court, rent tribunals, mental health tribunals, schools, crisis support, disciplinary boards, legal issues, and
- a wide range of therapy and prevention programs.

Winnunga programs which include the Youths at Risk Program and the Home Maintenance Program are instrumental in helping community members at risk. Winnunga also auspices Dyrimal Migay (*Proud Young Women*), a refuge for young Aboriginal girls in the ACT aged 12 to 17 years. The Aboriginal Midwifery Access Program encourages women to access treatment at an early stage and delivers one-to-one care for clients with social and emotional issues as part of the philosophy of continuity of care (Winnunga 2005).

The Muuji Regional Centre for Social and Emotional Wellbeing was established in 2000 as part of the National Regional Centre Program for Social and Emotional Wellbeing established by the Australian Government in response to the findings of a number of key reports including the 'Bringing Them Home Report' (HREOC 1997). The Muuji goal is to build and continually reinforce a culture of learning, partnership and community support. The strategic objective of the Muuji partnership (of which Winnunga is a part) is a skilled workforce responding to the needs of Aboriginal peoples and communities in the three areas in which the health services operate in South East NSW and the ACT (Muuji undated). Consequently, Winnunga delivers health training accreditation programs including:

- Aboriginal Health Worker Training;
- Certificate II in Automotive Vehicle Servicing;
- Training in working in the Aboriginal Arts and Entertainment Industry and a combination of personal development and work ready skills for youth at risk; and
- Strong Spirit, Strong Mind National Indigenous Alcohol and Other Drug Worker Training Programs (Winnunga 2006).

While the RCIADIC recognized the importance of an appropriately qualified

workforce, it also identified a number of AMSs providing prison health care examined in the following section (Reconciliation and Social Justice Library, 1996).

7.4 Other Aboriginal Health Services' Prison Health Work

The RCIADIC found that some progress had been made in Aboriginal health service delivery in prisons in many Australian States with different arrangements in place from one location to another. For example, it found that the Queensland Aboriginal and Islander Community Health Service attended three Corrections Centres in the Brisbane metropolitan area. In NSW a medical practitioner from the Redfern AMS attended the major metropolitan prisons on a regular (although infrequent) basis. In the Northern Territory, an informal arrangement existed with the Correctional Service where medical practitioners from the Central Australian Aboriginal Congress in Alice Springs were given access to their patients at Alice Springs Prison on a needs basis (Reconciliation and Justice Library, 1996). When this study carried out a small purposive national telephone survey of AMSs providing prison health care, it found that these services have now been discontinued. It also found that the following AMS prison health services have been discontinued (personal communication with AMSs August 2006-March 2007).

- Danila Dilba Biluru Butjil Binnilutlum Aboriginal Corporation - health service to the Darwin Correctional Centre;
- Awabakal Medical Centre Newcastle - nursing services to the Cessnock Prison;
- Riverina Medical and Dental Aboriginal Corporation - health worker health promotion service to the Junee Prison; and
- Broome Aboriginal Medical Service - medical services to Broome Regional Prison.

The reasons for these changes are primarily due to difficulties in arranging professional indemnity with prison authorities as well as lack of AMS resources.

Examples of Queensland AMSs that continue to deliver various prison health services include the Wuchopperen Aboriginal Health Service in Cairns, which provides outreach at the Midin Aboriginal Clinic at Atherton for a medical practitioner to visit Lotis Glen Correctional Centre each week. A medical

practitioner from the Townsville Aboriginal and Islander Health Service visits the Townsville Correctional Centre once a week.

In NSW the social and emotional wellbeing staff health workers from the Wellington AMS visit the Wellington Correctional Centre once a week, and the Tamworth AMS conducts a vascular health program at the Tamworth Correctional Centre once a fortnight. The Hunter Valley Aboriginal Corporation at Muswellbrook has an Elders' Group visiting St Heliers Correctional Centre and provides a transport service for family visits. The Durri Aboriginal Corporation Medical Service provides a drug and alcohol medical practitioner, and psychiatrist once a week, an Aboriginal mental health worker three times a week, and a dental assistant twice a month to the new Mid North Coast Correctional Centre at Kempsey. Future plans for this service include the provision of a prison health team coordinator, and additional sexual, drug and alcohol, and maternal health workers and a dentist.

The Daruk Aboriginal Medical Centre in Mt Druit, Sydney, provides Aboriginal health worker services once a month to Emu Plains, Lithgow and John Morony prisons and a medical practitioner visits Emu Plains and John Morony prisons once a week. Bulgarr Ngaru Medical Aboriginal Corporation provide twice weekly Aboriginal health worker, sexual health worker, and mental health worker services to the Grafton Prison and health worker services to the Glen Innes Correctional Centre once a fortnight.

Various prison health service arrangements are in place in Western Australia. The WA Derby Aboriginal Health Service Council Aboriginal Corporation has a formal arrangement with the Derby Prisoner Work Camp to provide primary health care to those inmates that are soon to be released. The WA Mawarnkarra Health Service Aboriginal Corporation at Roebourne, conducts informal counseling visits to the Roebourne Regional Prison. The WA Ngunyntju Tjuju Purni Aboriginal Corporation Women's Group in Kalgoorlie visits female Aboriginal prisoners at the Eastern Goldfields Regional Prison, and conducts pap smear and diabetes health programs. The WA Ord Valley Aboriginal Health Service in Kununurra visits Police holding cells once a month. Aboriginal health workers from the Derbarl Yerrigan Aboriginal Health Service in East Perth visit the Acacia Prison and the Boronia Pre-release Centre for Women in Perth (on an irregular basis) to provide diabetes screening and education. The Acacia Prison will, at times, request that a medical practitioner visit from the Aboriginal Health Service. An Aboriginal

health worker from the Southern Aboriginal Corporation in Albany WA visits the Albany Regional Prison.

In Adelaide, South Australia, the Nunkuwarrin Yunti AMS prisoner health team provides access to culturally safe and culturally secure services to support the health and wellbeing of Aboriginal people returning to the community from prison and to those with complex needs in prison. The prison team comprises two full-time Aboriginal health workers and a community medical officer. They provide clinical services during two sessions per week each at the Adelaide Remand Centre and the Yatala Labour Prison. The Port Augusta Pika Wiya Health Services provide medical practitioner services once a week to the Port Augusta Prison. The Tasmanian Aboriginal Centre Incorporated in Hobart provides weekly Aboriginal health worker and counselor services to the Risdon Prison and Hayes Prison Farm.

In Victoria the Ngwala Willumbong Co-operative provides a drug and alcohol program delivered by Aboriginal health workers to Barwon and Port Phillip Prisons and the Fulham Correctional Centre. The Victorian Aboriginal Health Service Co-operative provides a women's and children's in-house service to the Dame Phyllis Frost Centre on request. The Mildura Aboriginal Corporation provides a medical practitioner and nurse and Aboriginal health workers to Warakoo Prison Farm on request. An Aboriginal health worker from the Bendigo and District Aboriginal Corporation visits the Bendigo and Loddon Prisons to assist with services on release from prison (personal communication with AMSs August 2006-March 2007).

7.5 Interrelated Health Problems Arising in Prison

Winnunga's experience in delivering health services to several prisons over a considerable time has highlighted the prevalence of health needs relating to substance abuse, mental health and communicable diseases. In a European study Tomasevski (1992) has also identified these three critical closely interrelated health problems arising in prisons. These negative health effects of imprisonment continue into release from prison, and manifest in harm resulting from inappropriate imprisonment of people requiring facilities not available in prison for mental health problems, the risk of suicide and self-harm, and the need to reduce the risk of drug overdose on release (WHO 2005a: 5). Clear & Cadora (2003) also write about innovative approaches to justice and incarceration proposed internationally.

Of the 99 deaths in custody the RCIADIC investigated, alcohol and drug abuse was a prominent feature (Commonwealth and State Ministers 1992: 46). Recent WA studies show that within 6-12 months of release, the risk of death is around three times greater for Aboriginal prisoners, than for Aboriginal people in the community. The main causes include suicide, drug and alcohol misuse, and motor vehicle accidents (Stewart et al. 2004).

Aboriginal women comprise about 8 per cent of the Aboriginal population in prison in Australia and experience higher rates of substance use and mental health issues than Aboriginal males. Because they represent a minority of the prison population, there are inadequate facilities for women at different security classification levels, and they do not enjoy the diversity and extent of programs available to male prisoners. They also have specific health issues. For example, the behavioural risks associated with cervical cancer are more common in women prisoners. In addition, the high levels of post-traumatic stress disorder in Aboriginal women are linked to life histories and level of child abuse, neglect and family violence (SCATSIH 2005b). While Aboriginal prisoner health needs include the need for culturally sensitive health programs that target early detection of chronic diseases, the issues of substance abuse, mental health, communicable diseases and women's health in prison predominate in Australian and overseas prison health literature as requiring special attention. They are discussed in the following sections.

7.6 Prison Mental Health – Australian Perspectives

From an Australian perspective, SCATSIH (2005a,b) reported that mental disorder is a consistent illness in prisoner populations, and they are more likely than the general population to have a psychotic illness, major depression and a personality disorder. The NSW Corrections Health Service mental illness survey (Butler & Allnut 2003) found that psychosis, anxiety disorder, affective disorder, substance use disorder and personality disorder in the NSW inmate population are substantially higher than in the general community – 74 per cent vs. 22 per cent. SCATSIH (2005a,b) also found that Aboriginal people are a particularly vulnerable group in the prison population necessitating that they receive assessment, treatment and rehabilitation appropriate to their needs in mental health, and respectful of their culture.

As recently as May 2006, NSW Supreme Court Justice, Michael Adams declared that it was a disgrace that he had been forced to send a mentally ill

man to prison because there was no place for him in the mental-health system as opposed to obtaining community-based health care. His sentiments are a reflection of the general concern that prisons have become de facto psychiatric institutions in Australia. A lack of community services for people with mental illness has meant that they can come to the attention of the Police and very easily be convicted of minor misdemeanors (Wynhausen, *The Australian*, 27 May 2006).

Snowball & Weatherburn (2006) found that there is an increase in Aboriginal incarceration rates in NSW notwithstanding the RCIADIC recommendations designed to reduce the rates of Aboriginal incarceration. The November 2006 coronial findings into the death of Mulrunji Doomadgee at Palm Island indicate continued targeted treatment by the Police of Aboriginal people (Behrendt, *National Indigenous Times*, 16 November 2006).

Apart from indications of continued incarceration of people with mental health disorders the Australian Law Reform Commission (ALRC 1988) reports that every jurisdiction in Australia has reformed or proposes to reform its laws for the mentally ill and intellectually disabled. Although the special sentencing options available to courts sentencing mentally ill and intellectually disabled offenders are not available to federal or ACT offenders, the following examples provide an indication of progress in this area. The Special Circumstances Court in Brisbane, Queensland is for homeless people who are mentally ill or intellectually disabled. It is run in the same manner as the special court in Perth, WA which has a special list one day a week for people with intellectual disabilities. Defendants' cooperation in undertaking anti-drug courses or other counseling, obtaining work, or independent living arrangements are taken into account when they are sentenced. In addition, the Disability Law Project in Queensland, a legal aid service for people who are mentally ill or intellectually disabled, results in 70 per cent of its clients having no conviction recorded. Similarly, Victoria's Koori Courts, South Australia's Nunga Courts, Queensland's Murri Courts and Circle Sentencing in NSW, WA, and the ACT (for those who plead guilty or have been found guilty) attempt to address the social problems beneath the legal issues for those committing minor misdemeanors (Wynhausen, *The Australian* 27 May 2006).

In May 2006, the Australian Medical Association (AMA) Report Card on Indigenous Health called for State, Territory and Federal Governments to decide that imprisonment is the last resort for Aboriginal people with mental health

problems (AMA 2006). The AMA stated that prisoners should be screened by a mental health team within 48 hours of their remand or sentencing, and when required, be treated for mental health problems rather than imprisoned. The current ACT Mental Health Act 1994 provides for the courts to divert mentally ill people to the health and community care systems for assessment and assistance. It is the intention of the ACT Government Discussion Paper on the Review of the ACT Mental Health (Treatment and Care) Act 1994 (ACTG 2006a) to consider how to provide mental health treatment and care at the earliest possible time for people detained in the new ACT Prison.

A significant initiative is practiced by the NSW Statewide Community and Court Liaison Service under the jurisdiction of Corrections Health Service. This is a court-based diversion for persons with mental health problems facing minor offences where the process of prosecution has commenced in local Magistrates' Courts. Mental health assessment and psychiatric triage is provided in the courts and in holding cells. This initiative may divert people with mental health problems to mainstream mental health on bail or alternatively, if bail is refused, they receive mental health treatment in correctional settings. An evaluation of the effectiveness of these services for recidivism and re-hospitalisation is yet to be carried out (Greenberg & Nielsen 2002).

7.7 Prison Mental Health – Overseas Perspectives

Ahmed Okasha (2004) President of the World Psychiatric Association (WPA) also reports that some WPA member societies are concerned about the incarceration of mental patients in prisons, particularly in the USA, because few prison diversion programs have been adequately implemented. The WPA estimates that 16 per cent of the two million prisoners in the USA are mentally ill. The WPA also found that in India there are equally high figures of mental patients in prisons, and in several other countries mental patients are in prisons because they were not examined before being convicted of a crime. Samples of USA prison inmates and Canadian penitentiary inmates reveal a higher prevalence of mental disorders - such as schizophrenia and major affective disorders - within these facilities than in the general population, with most of the mental disorders present before incarceration. In the UK prison system, 90 per cent of prisoners have a mental health problem and/or a history of substance misuse (Anonymous 2006).

A study of sentenced and remand inmates in the UK found that hospital admission was recommended for 88.2 per cent of the psychotic sentenced prisoners and 80.6 per cent of psychotic prisoners on remand (Gunn et al. 1991). A later study of the prevalence of mental disorder in the male remand population in England and Wales found that 55 per cent were judged to have an immediate treatment need such as transfer to a hospital bed (9 per cent), treatment by prison health care services (17 per cent), motivational interviewing for substance misuse (15 per cent), and therapeutic community placement (14 per cent). The study concluded that mental disorder was common in the remand population, and psychosis was four or five times the level found in the general population (Brooke et al. 1996).

A 2001 study which identified the level of psychiatric need within the New Zealand prison population found that a significant number of inmates suffered acute psychotic illness and required inpatient psychiatric hospitalization. In addition, large numbers of inmates required ongoing psychiatric treatment within the prison system (Brinded et al. 2001). A further study found that Maori suicides were over-represented in the prison population, both in relation to other prisoners and the non-imprisoned population. This suggests there is a major issue of psychiatric morbidity as well as an unmet need for assessment and treatment for Maori prisoners (Simpson et al. 2003).

7.8 Substance Misuse – Australian Perspectives

Drug Courts operate in NSW, Queensland, SA, Victoria and WA. However the processes and procedures of these courts differ across jurisdictions. The main aim is to divert illicit drug users from prison into treatment programs (AIC 2006). For example, in Queensland the Drug Court has been set up to sentence people who have pleaded guilty to certain drug-related offences in the Magistrates Court. It offers offenders the chance to take part in an intensive drug rehabilitation order as an alternative to prison (Queensland Government 2006).

SCATSIH (2005a,b) examined substance misuse in the prison population. They found that many Australian surveys of prisoners have shown that while there is a gap in national data, many prisoners have histories of substance abuse. In NSW 64 per cent of men and 75 per cent of women screened on correctional system reception had a 12 month diagnosis of substance use disorder. In 2002, 23.5 per cent of Aboriginal people aged 15 years and over reported using

substances (mostly marijuana) over the last 12 months. A study of Aboriginal injecting drug users in Sydney by Day & Dolan (2001) noted the difficulty in determining the level of injecting drug use in the Aboriginal population. In a national study of injecting drug users, 13 per cent of the NSW sample were Aboriginal Australians compared to 5 per cent of the national sample (Rutter et al. 1996). Day & Dolan's 2001 study found that Aboriginal people are over represented among injecting drug users in Sydney, particularly females, and were more likely to be imprisoned than non-Aboriginal injecting drug users. They considered that prison may be an opportunity to promote treatment and blood-borne virus testing given the high rate of incarceration of Aboriginal injecting drug users.

A strong supporter of pragmatic, public-health-based harm reduction approaches, Dr Alex Wodak, the director of St Vincent's Hospital's (Sydney) alcohol and drug service, contends that Australia's drug problem will worsen if governments continue to treat substance abuse as a law-enforcement matter as opposed to a health issue. Dr Wodak considers that lower levels of deaths, diseases, crime and corruption are not achievable unless Australia follows other countries in adopting a health based approach (*The Canberra Times*, 'Treat drug abuse as health issue', 4 July 2006, p 7). In the instances of drug injecting in prisons, WHO (2005a: 5-6) proposes the following definition for harm reduction:

In public health relating to prisons, harm reduction describes a concept aiming to prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment and overcrowding as well as adverse effects on mental health.

The ACT Government commissioned Dr Wodak and colleagues in 2001 (see Rutter et al. 2001) to review international research about prison-based needle and syringe programs. The Australian part of the research found that a study on the feasibility of a prison needle and syringe program in NSW had been conducted in 1995. This study recommended a two year evaluation of inmates and staff, testing prisoners for blood-borne viral infections and drug use, and reviewing prison records for assaults and/or drug seizures. The Australian data also showed that the successful record of risk reduction by injecting drug users in the community was in contrast with reports of high risk behaviour in prison.

Rutter et al. (2001) concluded that prison can be a place where people start injecting. Dolan et al. (1998) found 10 per cent of injecting drug users in NSW prisons reported commencing injecting in prison. This was also borne out in a Victorian study where the spread of blood borne viral infections was also attributed to the turnover of new partners and mixing (bringing disparate individuals together). This is the only study to examine this way of transmission in prison. It found that among the injecting drug users who shared syringes, 71 per cent reported that their sharing partners were either from a different or unknown location compared to 31 per cent of injecting drug users who shared syringes in the community (Crofts et al. 1996).

Injecting drug users more commonly experience multiple episodes of imprisonment than other inmates (Rutter et al. 2001: 17). A 1994 study of NSW prisoner entrants found 31 per cent tested positive for hepatitis B and 37 per cent for hepatitis C (Butler et al. 1997). In 1992 all prison entrants in Victoria were screened for hepatitis B, C and HIV. The incidence of hepatitis B and C was high (12 per cent and 18 per cent respectively) but not HIV (0 per cent) among those who entered prison twice during the study year. The study showed that recidivist prisoners have a very high incidence of hepatitis B and C but could not establish whether infection occurred inside or outside prison (Crofts et al. 1995). As at 2001, five instances of hepatitis C transmission in prison had been documented in NSW (Post et al. 2001).

The 2004 Australian prison entrants' blood-borne virus and risk behaviour survey (Butler et al. 2007) in NSW, Queensland, Tasmanian and WA prisons found that prisoner populations are vulnerable to blood-borne virus infection particularly hepatitis B and C. Aboriginal prison entrants are more likely to be hepatitis B core antibody positive and are also more likely to be immune through vaccination. The survey found there was room for improvement in hepatitis B vaccination coverage and completion rates for susceptible Aboriginal and non-Aboriginal groups. The survey concluded that the low prevalence of HIV among prison entrants and injecting drug users in the community is likely to be due to the widespread introduction of community-based needle and syringe programs in the 1990s. In addition, sharing injecting equipment has been identified as a potential risk factor for viral hepatitis transmission but not for HIV transmission. Sterile injecting equipment is not available in any Australian correctional jurisdiction.

7.8.1 HIV Education in Australian Prisons

Australian prisons systems are operated at the state level and the availability of voluntary testing for HIV can be a problem. Compulsory testing for HIV occurs in some Australian jurisdictions (e.g. the Northern Territory) while screening for other sexually transmitted and blood borne viruses is conducted to varying degrees in other jurisdictions (Levy 2005). However HIV education in prisons has been co-coordinated at the national level (Robinson 1994). For example, during HIV educational courses in NSW prisons, inmates were trained to provide information and bleach to other inmates with the result that their HIV knowledge was very high (Taylor 1994). Evaluation of hepatitis education is limited. The NSW Department of Corrective Services has developed a comic book *Skin Deep* to address hepatitis C in prison with positive results in information comprehension (Dolan & Rouen 2003).

7.8.2 Condom Provision in Australian Prisons

Condoms have been available to inmates of the Belconnen Remand Centre in the ACT since 1994, but not necessarily distributed (Levy 2007). Following a successful condom trial conducted in three NSW prisons in 1996, the introduction of condoms and dental dams into Correction Centres was under consideration at the time of the 1997 NSW Inmate Health Survey. The Survey recorded that males generally opposed the introduction of condoms for reasons that it would increase the incidence of sexual assault. However, females supported the introduction of dental dams for reasons of safer sexual contact and prevention of the spread of disease (Brown & Butler 1997). Five years after the introduction of condoms into NSW prisons an evaluation study found there was a decrease in reports of both consensual male-to-male sex and male sexual assaults. The study concluded that there was no evidence of serious adverse consequences of distributing condoms and dental dams to prisoners in NSW and they should be made freely available to prisoners (Yap et al. 2006). Condoms are currently available in prisons in NSW, WA, ACT and Tasmania. However, the Prison Officers' Union in South Australia has blocked their provision and they have been withdrawn in Queensland prisons for financial reasons (Levy 2005).

7.8.3 Bleach Programs in Australian Prisons

There is some uncertainty about bleach and its effectiveness in the decontamination of hepatitis C infection from injecting equipment (Rutter et al. 2001). Liquid bleach (i.e. domestic cleaning material) has been available to NSW inmates since 1991. A study into bleach availability in prison in NSW found that although less than one third of respondents in the study who injected in prison reported that disinfectants were easy to obtain, most of the respondents who shared syringes in prison had used disinfectants to clean injecting equipment. However, the study concluded that three years after the distribution of disinfectants began, most inmates found it difficult to gain easy access to them. A serious problem of the effectiveness of bleach as a decontaminant was also identified in the study, necessitating further research to develop more effective syringe decontamination and alternative methods of distributing disinfectant. The study also found that some prisons are using a new method of distributing bleach via dispensing machines (Dolan et al. 1994). The policy of making bleach available exists in all other States and Territories except South Australia. However, the application of this policy varies (Levy 2002).

7.8.4 Methadone Maintenance Treatment in Australian Prisons

The National Drug Strategy - National Policy on Methadone Treatment (CDHFS 1997) cites the conditions when methadone treatment is appropriate for prisoners. The conditions are: for withdrawal; for continuation of methadone treatment; for those who are heroin dependent on prison entry or have used heroin in prison in a harmful way, including those who are HIV positive; and to reduce intravenous opioid use upon release. A study which monitored the NSW prison methadone program found that methadone treatment significantly reduced the heroin injection and associated criminal activity (Gorta 1992). In other Australian jurisdictions, prisoners in South Australia, Queensland and Tasmania can continue methadone treatment when they enter prison. In Victoria, small numbers of prisoners serving short sentences receive methadone treatment. The ACT Government Sub-Committee on Syringe Exchange and Drug Use for People in Detention in the ACT in 2000 stressed demand reduction as the preferred strategy against drug use in prison. However they accepted the need for harm reduction strategies for prisoners continuing to inject drugs (Rutter et al. 2001: 24, 25).

The following section examines the incidence of substance misuse in European prisons. It also considers the effectiveness of needle and syringe prison programs as part of harm reduction. This philosophy adds a valuable element to the health care and treatment of drug dependent prisoners and reduces the health risks to prison personnel (WHO 2005a: 7).

7.9 Substance Misuse – Overseas Perspectives

Aboriginal people in Canada are over represented in groups at high risk for HIV infection, particularly among injecting drug users. Less than 3 per cent of the national population in Canada is Aboriginal, however Aboriginal people represent 15 per cent of the federal prisoner population. A 1999 judgment of the Supreme Court of Canada said that prison had replaced latter-day residential schools as the likely fate of many Aboriginal Canadians today (Canadian HIV-AIDS Legal Network 2004: 1).

The Canadian HIV-AIDS Legal Network noted that since 1996 some positive developments had occurred in the Correctional Service Canada (CSC) in their responding to HIV/AIDS and hepatitis C in prisons – most notably providing methadone maintenance treatment. However, it noted that the CSC was far removed from having a proactive response to these issues. For example, the methadone maintenance treatment had only become available after the CSC was sued by prisoners for failing to provide adequate care. Access to condoms, dental dams, lubricant, and particularly bleach (which is diluted so as not to be effective) has decreased in recent years. The CSC set up a pilot program to train inmates to provide safe tattoos to prisoners. The program worked with strict controls on the tattoo equipment so that it stayed within the confines of the prison tattoo parlour (Prisonjustice.ca, 2005). The head of the Public Health Agency of Canada considered that the program was a key component in reducing the spread of infectious diseases in prisons. However, the program was cancelled after a year because it did not demonstrate that it was effective (Anonymous 2007).

Prisoners are still denied access to sterile injecting equipment although injecting drug use is prevalent in federal prisons across Canada. There is inadequate implementation of the Peer Education and Counseling program, and people are still dying in prison from HIV-related illnesses due to lack of adequate compassionate release provisions. The federal prisons ombudsman has called for needle and syringe programs in Canadian penitentiaries notwithstanding

the CSC's continued disregard of such recommendations (Prisonjustice.ca, 2004). The Canadian HIV/AIDS Legal Network (2004) has advocated for prison needle and syringe programs to be introduced in Canadian prisons, in view of the WHO Europe research findings on needle and syringe programs in European prisons (described below). The Network also considers there is no longer any good reason to deny prisoners who inject drugs access to clean needles, and that this initiative should accompany other harm minimization efforts such as drug treatment programs and methadone maintenance.

Hepatitis B and HIV were transmitted during January to June 1993 inside Glenochil Prison in Scotland. Studies found that a quarter of injecting drug users had started injecting while in some prison, and between a quarter and a third of men who injected drugs in Glenochil Prison, in the transmission timeframe, became infected with HIV while in prison (Gore et al. 1995). Another Glenochil Prison study found that acute hepatitis B was the earliest indicator of the possible occurrence of HIV transmission, and all infected inmates had shared injecting equipment in the prison (Taylor et al. 1995). A subsequent study of eight Scottish prisons found that prison mandatory drug tests had caused inmates to change their drug use to opiates such as heroin (McDougall 2007).

The WHO Health in Prisons Project addresses health and health care in prisons (WHO 2007). The drug problem is prevalent in European prisons. The WHO (2005a) status paper on prisons, drugs and harm reduction found that many people entering prisons have a severe drug problem. In European countries and Norway between 22 per cent and 86 per cent of the prison population report using an illicit drug. Cannabis is most frequently used at 11-86 per cent, with cocaine (and crack) use at 5-57 per cent, and heroin 5-66 per cent. European prisons are high risk environments for HIV transmission. This is linked to sharing injecting equipment (at a higher rate than among injecting drug users outside prison), unprotected sexual encounters and tattooing. Consequently there are high prison rates of sexually transmitted infections and hepatitis B and C. Published studies have found that 20-40 per cent of prisoners have hepatitis C. Rates of hepatitis C in injecting drug users are two to three times higher than among prisoners with no history of injecting drug use (WHO 2005a: 2-3).

The rates of HIV infection in Europe and central Asia are much higher among prisoners than among the general population. In European countries there

is significant variation in the rates of HIV infection among prisoners. For example, they are higher in Eastern Europe (e.g. Estonia with 12 per cent in 2002) and in some Western European countries such as Portugal (11 per cent in 2000). However in England where there are prevention interventions in place the HIV prevalence rates among prisoners are less than 1 per cent (WHO 2005a: 2-3).

The introduction of harm reduction measures is relatively new to prison systems as this can be perceived as threatening to prison abstinence drug policy. Other reasons are the danger of an increase in injecting drug use, accidental needle pricks, and conflicts between prisoners or between prisoners and staff. There is also the fear that syringes or needles will be used as weapons. However, there is evidence that the needle exchange schemes introduced into six European countries: Belarus, Germany, Kyrgyzstan, Republic of Moldova, Switzerland, and in all Spanish prisons do not have these problems (Lines et al. 2004).

The rationale for harm reduction in European prisons is based on public health principles and human rights. Most of the 15 members of the European Union (prior to May 2004) follow harm reduction measures although application may be inconsistent between prisons, and within prisons for blood screening, vaccination programs, and disinfectants. As well as needle and syringe programs they include the following prevention programs for reducing drug dependence and can also be applied for alcohol abuse and unsafe sexual practices.

- Information, education and communication on HIV/AIDS;
- Voluntary testing and counseling;
- Distribution of condoms;
- Bleach or other disinfectants;
- Substitution therapy; and
- Treatment and care for HIV/AIDS, hepatitis and tuberculosis, and antiretroviral therapy.

The overall conclusions of the WHO (2005a) paper on drugs and harm reduction in prisons are that although introducing needle and syringe exchange schemes in prisons depends on the degree of injecting drug use and the prevalence of HIV and hepatitis, there are also significant advantages of using substitution therapy. These advantages include reducing suicide and self harm during withdrawal, improving management problems during withdrawal, and

reducing the risk of fatal overdose on release from prison. The WHO (2005a) paper concludes that action is required in the interests of public health to add to the successful experiences in several countries in Europe of helping prevent the transmission of HIV/AIDS in prison communities.

7.10 Women Prisoners' Health – Australian Perspectives

Holly Johnson's Australian Institute of Criminology study of incarcerated female offenders in Australia found that in 2003 the imprisonment rate of Aboriginal women was approximately 15 times higher than the rate for non-Aboriginal women (Johnson 2004; ABS 2004). Aboriginal women and their children are victims of racism, sexism and violence in Australian society. They are 'significantly over represented in the criminal justice system both as victims and prisoners, often as both' (Kilroy 2004: 10). In writing about the Queensland experience, Debbie Kilroy, the Director of Sisters Inside identifies two factors within this complex issue as the reasons for over-representation. They are: (a) discrimination in the criminal justice system in its treatment of Aboriginal people; and (b) Aboriginal people commit disproportionately more offences because of their marginalized status in society (Kilroy 2004: 10).

Johnson (2004) found that Aboriginal women report higher rates of violent offending, lower property offending with the exception of burglary, and much lower participation in fraud offences. They are less likely than non-Aboriginal women to have a history of drug crimes and sex work. Aboriginal women tend to have higher levels of alcohol dependence and are more likely to attribute their offending behaviour to alcohol abuse. However, there are substantial levels of drug dependency among Aboriginal and non-Aboriginal female offenders. Johnson's study concluded that early intervention with Aboriginal women and treatment for sexual and physical abuse, mental health and alcohol and drug abuse problems may reduce contact with the criminal justice system (Johnson 2004: 9).

The NSW Select Committee on the Increase in Prisoner Population (2000) found that women prisoners are generally unemployed, have poor literacy, use drugs and suffer from mental illness and chaotic personal lives. One of the greatest impacts of imprisonment on Aboriginal women is the disruption to the family life of children. In most instances imprisonment costs them contact with their children because of the distance between the prison and

where the children live. This impacts on the women, the children and the community who remain to care for the children. Pregnant Aboriginal women prisoners often suffer poor health and need prenatal support, support during labour, and access to family and their baby after birth (HREOC 2003). The Australian Medical Association is adamant that infants should be born in a hospital outside the prison. If this cannot be arranged this fact must not be recorded on the birth certificate. The infant should remain with the prisoner (who should have sufficient care facilities) at least until the age of two years and must have adequate nutrition and access to paediatric care (AMA 1998).

As well as loss of services during incarceration such as housing, medical or dental programs, an Aboriginal woman's sense of shame can be a strong barrier to accessing vital support on release and some become itinerant as a result. A major issue faced by women in prison is the knowledge that they may lose their homes if rental payments are not maintained. They are triply disadvantaged because they suffer the results of incarceration common to all prisoners. In addition, they experience cultural dislocation, and isolation from being imprisoned far from home and family (HREOC 2003).

There are indications that the cycle of prison and poverty brings on early death. Victorian research found that 93 women died within 18 months of being released from prison during a 10 year period in the 1980s and 1990s (*Sydney Morning Herald.com.au*, 1 December 2001). Only 2 of the 62 deaths examined were from natural causes. Of the 45 who died of drug-related causes, 6 were dead within 2 days of release, 11 within 14 days and 22 within 3 months (*Sydney Morning Herald.com.au*, 1 December 2001). Guthrie et al. (2003) measured female inmates' health service satisfaction in two NSW prisons, and found that Aboriginal women appeared to be more satisfied with the health care they received in prison than non-Aboriginal women. They concluded that the satisfaction was high due to each Correctional Centre being served by an Aboriginal Medical Service.

Dr Eileen Baldry of the University of NSW (*Sydney Morning Herald.com.au* December 1, 2001) is not alone in considering that:

Women are never better off after going to jail. Their lives unravel. Some of them are almost demented with worry about their families. For most of them it continues a terrible cycle of poverty and abuse. People who want to have peaceful lives must realize that prisons will not make the community safer.

A study of Aboriginal women in NSW prisons, carried out on behalf of the Aboriginal Justice Advisory Council, found that over representation of Aboriginal women in prison must be dealt with by developing strategies associated with their abuse, drug addictions and in addressing lack of education and employment opportunities (Lawrie 2002). The study concluded that addressing these underlying causes of offending would assist generations of Aboriginal women. The issues Australian Aboriginal women in prison encounter are not dissimilar to overseas experiences examined in the following section.

7.11 Women Prisoners' Health – Overseas Perspectives

The WHO (2005b: 31) predicts that a study of women in prison will become a priority in future years, due to the vast increase in the proportion of women in prison in some countries. For example, in England and Wales from 1992 to 2002, the number of male prisoners increased by one-half, while the population of women in prison increased by 173 per cent. Women prisoners represent a needy population – over one third have previously tried to commit suicide in England and Wales; about one in four is a harmful or a dependent drug user; about half are victims of domestic violence; and up to a third have been victims of sexual abuse.

Aboriginal women represent between 1 per cent and 2 per cent of the Canadian population yet represent 27 per cent of the women serving federal sentences (Bailey 2003). Healing lodges for women present a place of healing rather than punishment. These alternatives to incarceration help women obtain education, job training, and treatment for substance or sexual abuse. There are indications that this approach is having a positive effect in view of a low federal recidivism rate for some Aboriginal healing lodge participants (CSC 1989).

Fifty (50) per cent of women classified as maximum security prisoners are Aboriginal women. The reason is that they often go into federal facilities on lesser charges and commit infractions in prison that lead to longer sentences. This classification means that they have no access to core programs and services for women and are denied specific prison programs designed for Aboriginal Canadians. In addition, the women incarcerated in a men's prison are at risk from male violence and are denied equal access to the programs and services that men can access (Prisonjustice.ca 2003). The

Canadian Association of Elizabeth Fry Societies considers that Aboriginal women and women with disabilities suffer increased discrimination in prison because they are considered a higher risk. Women prisoners with mental and developmental disabilities also suffer discrimination in receiving higher security classifications and are incarcerated in prisons instead of receiving appropriate services in the community (Prisonjustice.ca 2003).

Prisonjustice.ca (2003) pays particular attention to the lack of health care services for women in prison in Canada. These differ from men's health care services and include adequate specialized care in gynaecology and maternity; treatment services for overcoming histories of drug and/or alcohol dependency; psychological, psychiatric and counseling services for overcoming abuse issues; and parenting services such as childcare and Elder care. Prison has the potential to increase Aboriginal women's vulnerability to HIV infection. They lack HIV information, services and supports, traditional helpers, and experience isolation from support in family contact. They are at greater risk for self harming behaviours due to their isolation and harsh environment (CAAN 2004). Injecting drug use among prisoners is a particularly high risk area because drugs and the equipment used to inject are illegal inside prisons. Consequently, prisoners are forced to share unclean needles and homemade injecting devices that damage the skin. If Aboriginal women prisoners are mothers, they can lack the daily incentives to be strong for the sake of the children and can suffer intense depression, suicide or attempt suicide (CAAN 2004: 7).

The findings in USA prisons are similar – the number of women in prison is increasing and most return to the community in a few days. McClelland et al. (2002) examined the HIV/AIDS risk behaviours of female prison detainees in Chicago, Illinois. They observed that many women at risk of HIV/AIDS i.e. those who use drugs, trade sex for money or drugs, are homeless and have mental disorders inevitably spend time in prison. They recommended that interventions such as HIV/AIDS education for women in prison must begin with those returning to their communities within days and must become a public health priority.

The following Chapters Eight to Twelve present the findings synthesized from ex-prisoner and family interviews, as well as interviews with representatives from justice, community and health organizations providing support to prisoners and their families.

Chapter Eight – Aboriginal Male Ex-Prisoners’ Perspectives of Prison Health

8.1 Introduction

Chapters Eight, Nine and Ten address Research Question 2:

What are the specific health services required for holistic health care service delivery to Aboriginal inmates in the ACT Alexander Maconochie Centre?

These chapters synthesise the perspectives of Aboriginal male and female ex-prisoners (Chapters Eight and Nine) and families of ex-prisoners and prisoners (Chapter Ten, which also addresses Research Question 1). This chapter analyses the data from interviews conducted with fifteen male ex-prisoners residing in the ACT/Queanbeyan metropolitan area (apart from one who is permanently resident in NSW). Chapter Nine analyses data received from female ex-prisoner accounts about incarceration. These perspectives focus on the health care they received in prison, with particular emphasis on mental health (including the impact of Corrective Services’ culture on mental health), and drug use in prison. They also provide the respondents’ perspectives about the health services to be delivered in the new ACT Prison. A comparison of male and female ex-prisoner perspectives of prison health discussed in this chapter is summarized at the beginning of Chapter Nine.

8.2 Personal Accounts of Incarceration – Male Ex-Prisoners’ Perspectives

The male ex-prisoner respondents in the study had experienced incarceration in the Belconnen Remand Centre in the ACT, and Correctional Centres throughout NSW including Goulburn, Cessnock, Long Bay, Lithgow, Metropolitan, Bathurst, Brewarrina, Glen Innes, Grafton, Junee, Kirkconnell, Mannus, Oberon, Silverwater, and Parramatta. The first five include maximum security in their Centres. One respondent had also been an inmate of three prisons in Queensland prior to being incarcerated in Goulburn, Junee, and Mannus prisons. All male respondents had been incarcerated as a result of drug and alcohol misuse. Following Cunneen’s (2002) findings on the offences committed by Aboriginal prisoners in NSW prisons, in the main, the crimes the respondents committed were petty theft, assault, and breaking and entering. Breaking parole was another reason for incarceration. The ABS

statistics show that 79 per cent of Aboriginal prisoners are aged between 20 to 39 (compared to 68 per cent of the non-Aboriginal population) (ABS 2005: 8). Of the fifteen male ex-prisoner respondents interviewed, twelve were aged between 18 and 39 years.

Interviewee A's story illustrates the complexity in the lives of male Aboriginal prisoners doing crime in their twenties and thirties. Interviewee A is aged between 18-25 years. He was a ward of the state and has a background of family trauma. He has a mental health, and alcohol and drug use history which escalated to drink driving offences, assaulting a police officer and breaching parole. At the time of interview Interviewee A was working at a peer driven organization which provides support for Aboriginal drug users, friends and families, run by Aboriginal ex-users, and trained as a Co-researcher for this prison study.

'I did stupid things: drink driving offences, assault on a police officer with a deadly weapon with intent to stab. I stole a vehicle and I was in a car chase. These were different episodes. My first charge was when I was 16 years. I was driving in a vehicle with no licence or registration and [it was a] stolen vehicle too. And we did four break and enters and then we were on the highway going back to go home and there was the police on patrol pulling people over for breath tests. We kept driving and I was with me brother boys, me cousins, and we got chased and then we got charged because we were driving on the wrong side of the road endangering the public, causing and inflicting harm on other people. I went to court and they let me off – or they put me on a bond and I had to do community service. And I did all that, and a couple of months later I started using heroin (I started when I was 17 using heroin) and hanging around Bernie Court [ACT government flats] and then I started doing stupid little things and they all added up like minor theft, theft, assault, drink driving again but not a stolen car. I assaulted a police officer with intent to stab with a deadly weapon and I got busted with a gram of heroin and I got let out on bail (they locked me up for that). I kept breaching my parole by not going to appointments, basically not going to nothing. I was just being running amuck. It is not like I was deliberately doing it ...it is just ...I was scared because I've been facing all these people all my life because I was a ward of the state and all my life I have had to answer to people. Why is it their business? It is my business and I don't ask them, know what I mean, and maybe the way I am now is because of my parents, not because of me. It is how I was brought up. I didn't choose to be like this all this lifestyle. It's how I was brought up and this is what I was introduced to. After breaching – it was all breaches - I did

not reoffend - I just kept getting breaches, so they locked me up to clean me up because I got mental health problems. I got bi-polar. I was diagnosed with bi-polar when I was 7 years old. It is not a drug induced thing it is actually a passed through gene. I don't see things. It is depression. I go up and down and I'm on medication for it but I am trying to reduce off the medication' (Interviewee A, 6 September 2006).

The male respondents in the study had been released from prison as recently as six months to three years previously. One respondent (Interviewee B, aged 55 years) had been placed on a good behaviour bond in 2004, after twenty-eight years of non-offending. His story, which follows, illustrates the trend of youth offending over two decades (in their twenties and thirties), and the subsequent desire to help young offenders in the community. It represents the trauma of being one of the stolen generations and commences with nine years of his young life spent in a Boys' Home. Then, prior to his turning 16 years, the Boys' Home sent him to prison. When he was released from prison the Governor of the Boys' Home asked him to talk to the newcomers to crime about prison life. In retrospect, he considers that he was able to influence them in a positive way, and in 2000 also assisted in setting up a therapeutic art group. His paintings represent his 'shame and pain' that he cannot verbally express. He currently teaches painting at a Mental Health Support Group. Interviewee B had his first daughter when he was thirteen years and the last child in June 2006. He has nine sons, five daughters, and thirty-seven grandchildren, has been married five times and is currently considering his sixth marriage.

'As I got older I moved to the criminal side of life, being in that situation of the Boys' Home and when I come out I had a lot of trouble getting a job. I had to lie and tell them I was Indian or Pakistani – I don't look Aboriginal; I don't have the big nose or big lips. I just tell them I don't fight. So I have to lie about my nationality. It affected me mentally bullshitting all the time so I actually turned to crime. I turned to cat burglary – while people are still in bed. I have retired. I have just found out that I had to go to court as I was accused of pinching this money from a club I was working at as a cleaner. But I proved to the Judge that I did not touch it. They even had pictures of me on the cameras and proved my hand did not go towards the money. This was 2 years ago. They put me on a 2 year good behaviour bond only because, I don't know, because I think I was Indigenous and they had to sentence me. But I was told by the Judge that I haven't been in trouble with the law for 28 years. That was good to hear that because I did not even know' (Interviewee B, 23 August 2006).

Interviewee B learnt to read and write through finding out the town names from truck drivers when he was hitchhiking around Australia. He did not go to school. Now he is writing material about his thoughts on psychiatry that he shows to his Psychiatrist. His poor mental health reflects ABS findings that stolen generations have poorer health in comparison to those who were not removed from their families (ABS 2005: 2-9). Interviewee B's story continues:

'Me brother and I were stolen from me mum and dad. Me brother turned to alcohol and he just turned into an habitual alcoholic. Me, I left Victoria and hitchhiked around Australia nine times. And now the family asks me to come back to Victoria and I can't because of the land marks there. We were sexually abused as kids before we were taken away. My so-called half brother, he died in 1989 of alcohol poisoning with a smile on his face. I wish he had died an ugly horrible death not only what he did to me and me brother but I found out what he did to a lot of other kids over the years. And he died in his sleep' (Interviewee B, 23 August 2006).

Interviewee B was incarcerated over thirty times in prisons in most Australian states. Among the other male respondents in the study, two ex-prisoners had experienced incarceration once, while the remaining eleven had been in prison between three and ten times. Overall, five respondents had been in Boys' Homes in their youth. Most prevalent were sentences of three to twelve months (mainly six months), following Cunneen's (2002: 25) NSW findings that the average length of imprisonment for Aboriginal people is 4.8 months (4.9 months for non-Aboriginal people). Cunneen's findings that there is a larger proportion of Aboriginal people in prison than non-Aboriginal people who have been previously incarcerated is reflected in the experiences of this study's male respondents. The prevalence of imposing six month imprisonment or less suggests that Aboriginal community generated alternatives to prison (such as community corrections) could provide some solutions (Cunneen 2002: 25).

Another respondent (Interviewee C, Interview 29 August 2006) in the older age range (36-45 years) had been in prison six times since his eighteenth birthday. He was released in 2005 after eight years in prison (crime not disclosed at interview). His experiences of prison were similar to Interviewee B (Interview 23 August 2006) and Interviewee D (Interview, 1 September 2006) who are in the same age range. At certain stages in their lives they had all reached the conclusion that they could use their life experience to be a

mentor to other prisoners, and to young Aboriginal men in the community. Interviewee C got to be in prison by:

'Just hanging with the wrong crowd really, and like got introduced to alcohol and drugs, and prison starts from there you know. Like each time I done something wrong, broke the law, the lag [the sentences] got bigger and bigger and every time I got out of prison I just, at that stage of my life, was on the merry go round in and out of prison back on the merry go round, back to prison. With this recent sentence I got, it was the biggest one I got and I had a lot of time to turn my life around. And the first way I changed it was when my wife and I actually got married. We got married back in '98. I was probably in prison - we just got married in prison and ever since then I've changed my way - done a lot of drug and alcohol programs, learned a lot about my body. I've done gym programs, other courses like forklifts, chainsaws, counselling and all that'.

'Mainly in the last four years of my sentence I was more a mentor for Aboriginal boys - talking, sit down listening to what they have got to say - just keep them calm and relaxed. A lot of them talked about suicide. I have been there, done it, it's not worth it. Life's more important, your family - you're not only going to hurt yourself, you're going to hurt the ones that love ya. It is a shame that they don't get an opportunity to talk about it at home before they go and do it. It is mainly fear that non-Aboriginal people put into them, even officers in the service..... By me helping them, I am learning myself. Just, it made me happier within myself that I am helping another brother'.

'Ten years ago, twenty years ago prison wasn't like that. It's all changed. But these days now, any brothers going to prison, they're going to prison with attitudes and leaving prison worse. So it takes them a long time. They sort of go on that circle, go out and come back in again, yeah. You try to talk to them and they'll sit and listen, but at the end of the day they walk away and they just don't give a damn, a lot of them' (Interviewee C, 29 August 2006).

In addressing the health care received in prison, four of the fifteen male ex-prisoner respondents had some understanding of holistic health. The remaining eleven thought it related to their physical condition or were not familiar with the term 'holistic'. The following section considers ex-prisoners' perspectives of the health care they received in prison.

8.3 Prison Health Care - Male Ex-Prisoners' Perspectives

Although it is commonly considered that prison is an opportune time to treat prisoners' health conditions, Levy (1999: 4) notes that Aboriginal inmates access clinics less than non-Aboriginal inmates (i.e. Aboriginal males 34 per cent compared with non-Aboriginal males 48 per cent). The following accounts provide an indication of the attitudes to accessing healthcare in prison. These perspectives varied from one respondent's experience of receiving extensive health care (some dental care with reluctance; other health care from necessity) to respondents who would not seek care because of long waiting times.

'You know, even though I had toothache I was frightened to go to a dentist. I had to go to the doctors and ask for the strongest painkiller tablets they've got. After a while I was starting to get addicted to it, so I got the courage up to go to the dentist, got the tooth out. And yeah, I had a little bit of an accident down here, got the old fellow caught in the zipper – this was back in '99. I wasn't circumcised, and when the scar healed up it healed up properly, you know? – but I had to go down to Long Bay and have an operation, had to get circumcised. Yeah. When I got that there done, the nurses had to change it twice a day, clean it – embarrassing. In a fuckin' room with about two or three nurses and you haven't got your trousers on. Back in 2000, that's when they diagnosed me with being diabetic. They tested my sugar when I was putting weight on, you know. I think they might have put it in the record down there, saying I'm diabetic but not giving me medication. I think stress played a big part, stress and worry, and it led to a heart attack, and I was rushed to hospital and the doctor in the hospital there gave me medication for diabetes. Well, for myself, my experiences, [of prison health] I reckon it ain't too bad. Like, the first couple of months they told me I was diabetic and not treating me or nothing. Ever since the heart attack, I mean, I just rock up to the window, get my tablets' (Interviewee C, 29 August 2006).

'There is no real health system in Goulburn prison. When I got sick I asked to see the Winnunga Doctor but by the time he got there I was well again. If I had been really sick they would have taken me to the clinic in the prison. Otherwise I had to wait my turn every time I was in prison' (Interviewee E, 11 September 2006).

Interviewee B (Interview 23 August 2006) endured any sickness or broken bones until he could not stand the pain any more because he knew he would have to go on the waiting list and it would be too long. Interviewee

F (Interview, 8 September 2006) did not worry about the bump on the head while in prison. Something happened to his head when he was arrested when drunk. He smashed into the concrete and a lump developed after a while. It took a long time before he was sent from Goulburn Prison to Long Bay Prison hospital. He still has headaches and has to see a doctor about it but has let it go. Interviewee G (Interview, 1 September 2006) saw the doctor in prison and had about twelve x-rays taken. He went into prison with injuries and did not get them attended to for a long time.

Interviewee H (Interview, 1 September 2006) took advantage of the prison health programs:

'Yeah I got plenty of medical help in prison because I went right through all their programs you know – got all my blood tests, all that done and everything come back tops, A1, you know better than average'.

While Aboriginal prison health needs include the need for culturally sensitive health programs that target early detection of chronic diseases, the issues of substance abuse, communicable diseases, mental health and women's health in prison require special attention. These issues are addressed in the following sections of this chapter. They have gained prominence in Australian and overseas prison health literature and are present in the experience gained by Winnunga through delivering health services to ACT remand centres and NSW prisons. In the following section the ex-prisoners' perspectives indicate that some may have been incarcerated with existing mental health problems. The effect on prisoners of the stress of coping in prison is also relevant to their mental health condition and is also examined.

8.4 Mental Health and Incarceration

Three ex-prisoner respondents spoke about their experiences in dealing with mental health needs in prison. Interviewee I (Interview, 30 August 2006) had recent experience of being treated for mental health in prison. He did not spend time in a prison cell during his sentence, but was put in a prison hospital ward and was in a medicated state much of the time. He stated that he was very frightened because sometimes he was in a ward with murderers. Interviewee E (Interview, 11 September 2006) was concerned that he had not received counseling about his mental health problems in prison. Interviewee B's experience is taken from prison life twenty-eight years ago:

'Seeing someone about mental problems is hard in prison. I found after I got

out it was too late – I needed someone in prison. I did not come out better. I was worse mentally. I have trouble now eating. I was dubious of eating the food in prison because I know half of the blokes who worked in the kitchen were poisoners. They only assess you on the type of crimes not health or your mentality. And they still do that today too. Most of the programs run in the prisons for drug and alcohol, you may as well say you are talking with another drug and alcohol person’ (Interviewee B, 23 August 2006).

A lack of community services for people with mental illness has meant that they can come, by default, to the attention of the Police and very easily be convicted of minor misdemeanors (Wynhausen, *The Australian*, 27 May 2006). This results in mentally ill people being sent to prison as opposed to obtaining community-based care because of the lack of places in the mental-health system. Unfortunately, the USA, Canada, UK and New Zealand prison mental health experience is similar. One system in Australia has merit. It is the NSW Statewide Community and Court Liaison Service under the jurisdiction of Corrections Health Service. This service provides court based diversion for persons with mental health problems, and diverts people to mainstream mental health on bail, or alternatively, if bail is refused, they receive mental health treatment in correctional settings (Greenberg & Nielsen 2002). There is no such service in the ACT. The ACT Mental Health has a role after the court appearance and on the Magistrate’s orders (Director, ACT Mental Health, Interviewee 31, 31 October 2006).

8.5 Mental Health and Coping with Incarceration

The following accounts indicate the difficulties in coping with prison life and the consequent stress experienced as a result. For example, some respondents coped with imprisonment by not thinking about life on the outside:

‘My contact was shut down for everything. The less the things that worry me, the less the things that get to me in prison. All I think about is getting out and picking up where I left off and that’s it. Back on track as they say’ (Interviewee H, 1 September 2006).

‘Told family not to come – did not like kids coming in. At school people get to know. A lot feel like that except those with only one child – they have to see the child. Indigenous people keep it from their kids and Indigenous medical staff going to the prison keep confidence as well. They do not do this in a white health service. Had to turn off because if I had not turned off I would have

tried to escape. I came out of Pentridge and find that my wife has put the two kids in a home. That hurt' (Interviewee B, 23 August 2006).

'I knew I was there, I'm here for a long time, just to make the best of it. Every day I just trained and kept myself occupied, and not go mad, really. It's not a nice place to be, but if you break the law it's where you end up. Yeah. Like, it's pretty hard in prison, like, not being with your parents, not being with your family at the time, you know, when they need you most. It's hard, but as I say, mentally and physically you've gotta keep yourself strong – especially being in prison, you can't show your weakness. Yeah, mm. You just gotta be strong. And the time more or less it is only going to the church, from the church to the road, you know, from the road back to prison handcuffed and everything' (Interviewee C, 29 August 2006).

'I was more shocked than anything else. Then when I got used to it I was right and I settled down. There was a change every day. It wasn't the same old thing – like something would happen. A couple of people would mess it up. In Goulburn it was scary because there were a lot of new people coming in because it was a transit prison and it was unpredictable' (Interviewee F, 8 September 2006).

'Just [coped]. I would always get back in a corner and just sit there and hope for the day the sun come up that I would be released. And that wasn't that it was written on a piece of paper saying you are to stay here for your crimes against whatever ... and when you do maybe we will let you out. I was only young and it was like being taken out of the closet and thrown into humanity, like into society. And when you get out into society the whole world is harsh – it is like dropping a little kitten into a pan full of pit bulls. I have done broken and enters and fight back at society because I want my mum to hear' (Interviewee J, 1 September 2006).

Interviewee E (Interview 11 September 2006) received the news of his brother's death while he was incarcerated and had to cope with the knowledge that he would not be able to attend his funeral because of his prison classification.

Other respondents found support within the prison population:
I would not be able to cope if I was all by myself without other brothers standing beside me that I know – my cousins or friends. If I had no one in prison I would be by myself because I don't trust no one. There is no trust

there; you don't know who they are or who they know' (Interviewee K, 14 August 2006).

'[Coped] just playing sports and keeping fit. Did not worry about the outside'. Interviewee L told his family to stay away until he was released. He was not lonely because he had a lot of cousins in prison (Interviewee L, 14 August 2006).

'I had the brothers in there and a lot of support – cousins' (Interviewee M, 30 August 2006).

'It is hard for the first month but after a while you get to know a few of the boys in there and you make it work sort of thing' (Interviewee D, 1 September 2006).

'I could not cope with that because my mum didn't visit me – no one did [in the BRC]. No one. My brother was in there the same time as me. Me and him visited each other. When we would visit each other because we're brothers right, even though we were locked up together because he was in another yard so I said can I see him, and they let us see each other. But I was sad because my mum wasn't there for me not at all, not at all, not even anything, money to help me get through. Luckily I got locked up with a pay cheque and then while I was in there I got another pay cheque because Centrelink didn't know. Of course the Youth Centre Social Worker visited but I mean like my mum - I wanted to see my brothers and sisters' (Interviewee A, 6 September 2006).

These accounts about the difficulty experienced in coping with prison life reflect the SCATSIH (2005a,b) view that mental disorder is a consistent illness in prisoner populations who are more likely than the general population to have a psychotic illness, major depression and a personality disorder. It emphasizes the importance of attending to prisoners' emotional wellbeing in a prison health model. In addition, the Corrective Services' assistance provided to prisoners has a bearing on their emotional wellbeing and ability to cope with the stress of imprisonment. For example, rules about contact with families, access to prison rehabilitation and education programs, the presence of Aboriginal Liaison Officers, and the prisoners' sense of safety are major issues.

8.6 Mental Health and Corrective Services' Culture

The state of inmates' mental health is also dependent on the attitudes inherent in Corrective Services' culture regarding family contact, safety in prison, the availability of rehabilitation programs and prison work, prison drug culture, and deaths occurring in the family.

The respondents' experience of contact with families while in prison varied due to their personal inclinations about wanting family contact. Some respondents were restricted in their family contact because of the distance, lack of family transport, and financial difficulties in traveling to prisons and staying overnight. (Some families were not aware of financial help in traveling expenses from the ACT Prisoners' Aid). Other prisoners did not have good literacy for letter writing, or the financial resources to telephone their families (incoming calls are not allowed). For those who wanted contact with their family, weekly visits, talking on the telephone and receiving letters helped in coping:

'Yeah, well, I think mentally she [wife] helped me a long way and all. Her and her kids and that, they'd be following me from prison to prison. And one of my sisters, like she used to travel down to Lithgow, and Goulburn. I wasn't much [at] letter writing. I'd write her a letter and phone her, talk to her, like, in the morning after you were let out of your room to see how her and the kids are. You know, keeping me strong love to her and the kids. I suppose if I didn't have her and the kids I'd be on the merry-go-round. But I made that choice, turned my life around. Cause I'm not getting any younger' (Interviewee C, 29 August 2006).

Interviewee N comments:

'I used to phone the family. It is OK but you only get \$12.50 a week and after getting supplies there is only about \$1 left for the phone' (Interviewee N, 8 September 2006).

The availability of education and rehabilitation programs also varied from 'sitting in the yard all day' in Goulburn Prison because of the programs not being available (Interviewees E, O, K on 11, 6 September, 14 August 2006), to attending rehabilitation programs. These included arts and crafts, work assessment, literacy and numeracy, anger management and institutional rehabilitation, bobcat, rehabilitation, counseling, body health, guitar, computer, and biblical programs. Two respondents stated that they were paid for working in prison (e.g. working on demountables, collecting papers in the compound, and kitchen work).

The introduction of Aboriginal Liaison Officers in the prison system is an important means of keeping Aboriginal prisoners in contact with their family and community. This happens in a variety of ways such as the Liaison Officers making phone calls to family on behalf of those who do not have the financial means to ring. They also assist in obtaining legal advice, having a yarn, and making character reference appearances in court. However some respondents found that there was an unacceptable waiting time to see the Aboriginal Liaison Officers in some prisons.

The issue of prisoners' safety arose when the male respondents were asked to comment on cultural groups housed together. This mainly occurs in Goulburn Prison and in the main those who experienced segregation found it was better *'because you are with your own kind'* (Interviewee L, 14 August 2006).

'The only dramas you had to worry about were just coming from your own people. We stick together, or you had to in Goulburn because you know it is you against the rest of them. So you are pretty united as one in there' (Interviewee O, 6 September 2006).

'I thought this was great because I knew I would be looked after by somebody that knows me, so I am not feeling on me own or out of place' (Interviewee G, 1 September 2006).

'Necessary for Goulburn because there are too many criminals who don't like blacks' (Interviewee N, 8 September 2006).

'It is good for younger brothers like being together' (Interviewee C, 29 August 2006).

'And some nasty things can happen. It was good being with Aboriginal people [in Goulburn] playing sport with them. Made it a lot more comfortable' (Interviewee D, 1 September 2006).

Interviewee K preferred prisons which were not segregated because *'the Elders stand over in Goulburn and are powerful. You can't dodge them; you are in the same yard and you can't move'* (Interviewee K, 14 August 2006).

Interviewee AA (Interview 25 August 2006) provides a female family member's perspective of segregation:

‘With the segregation for Kooris and others, because they have spent a lot of time in the prison systems they get to know the others. Some are in for quite a long period of time, and some of them are not coming up for release any time soon. So those people are generally still in there if they go back into the prison system, and because they are Aboriginals they create a family of their own. For some people it can be OK and for others, they don’t know too many women who go to prison. But from the young men’s perspective I can see that they blend in with each other and this makes time go a lot faster. I know from our kids that that’s what happens but by and large, it tends to make their time go better because they mix in with each other; they all sit around bitching about all things. And it is always good for family members not to relay any bad news. I guess it frustrates them because they can’t do anything while they are in there as they can sit there and let it fester and make their time harder’.

From a professional perspective when visiting inmates of the BRC, the Winnunga Psychiatrist addresses the psycho/social/cultural issues through structured, culturally appropriate interviews, working in conjunction with the Winnunga Doctor. Inmates need to be assessed as to whether their crime is related to their poor mental health, a psychotic illness, associated illnesses or whether they are having difficulties in speaking because they are locked up. They often perceive they are in an unfair system and are not being listened to. They do not manage the authoritative attitude in the prison system. The Winnunga Psychiatrist considers that restorative justice is more helpful for people with mental illness or disorder. The Aboriginal expression of distress might appear to be anger but is very often anxiety. Their grief and trauma (multi-generation trauma) is as a result of being affected by stolen generations issues. Some of the underlying issues that result in imprisonment are poor physical health and cultural differences – some are neither accepted by mainstream nor Aboriginal people. They can react in an overwhelmed fashion. People who have used drugs and alcohol are in an altered state. They either dampen their emotional state to endure emotional intensity or situations of distress whether perceived or real, but once they get to bursting point they have trouble containing themselves and often ‘act out’ their anguish. The Winnunga Psychiatrist considers that prison Aboriginal Liaison Officers are crucial in providing feedback on inmates’ mental and physical condition (Winnunga Psychiatrist Interviewee 23, 21 November 2006).

8.7 Drug Use in Prison

The following ex-prisoners' accounts provide an insight into their experiences of drug use in prison and blood-borne diseases contracted in prison:

'They check for nits and things like that but they don't have to deal with the problem of anything else – fuck that is your problem. As long as it does not affect them immediately [they don't check for HIV or Hepatitis C on release] they don't care. You are stuck in the yard and left to your own device. I just worked out and tried to stay out of the politics and eat healthy. Not much really to do. There is no help in there. If there is you've got to wait two or three months before you see anybody anyway and you don't need it then – you are out. It is a choice I made to do the seven day pill program in the Belconnen Remand Centre and within two weeks I was clean, so I did not have any drug dependencies while I was in Goulburn. And being in Goulburn is just an added pressure. People stand over you for your methadone and so it is just not worth it' (Interviewee O, 6 September 2006).

Interviewee K (Interview, 14 August 2006) did not go to any special health services while in prison. He looked after himself because he was recuperating. When he was incarcerated he was unwell from using a lot of drugs. Living at home with his mother now helps him to stay away from drugs, but he considers there was nothing to help him with getting off drugs in prison:

'The first time I went to prison [was] in 1997-98 for stupid reasons. I was only young and I ended up catching hep C in prison. And I disagree about not letting the program come through. There is heaps more stuff that could be done for people but they are not doing it. When boys first go in there and they are new to it and they are users, the first thing they do they ask the doctors for a couple of sleeping pills for the night to help them sleep. They don't come out of their cells in the morning. They just lie in bed for a couple of days, have a feed and once they start feeling better, then they come out and then start trying to get into the shit. If you are a user all you think about is one thing and one thing only, or two things – women and drugs – and you don't give a fuck about anything else; you contemplate suicide and whatnot – it is terrible, really terrible. It is just the games that the boys play with themselves when they get in there – it is silly. The Connection has helped me out once or twice, but we don't get as much help as we would like. Counseling would help and a program for when people come out. You have to wait for a house unless you put in for it at the start of your sentence. A hostel would help where people could go and be safe if they don't feel they want to go home, or a rehab would be good for brothers like myself' (Interviewee K, 14 August 2006).

Interviewees B, H and C also disclosed about taking drugs in prison:

'In Yatala (SA) I used to look after the people who used to do tattoos I used to look after their tattoo guns of a night time when they had finished of a day time doing tattoos. Not only that, I used to look after the hash and the marijuana and I used to look after everybody's money. But it was in my cell. It was only [because] the so-called heavies of the prison knew that I wouldn't touch anything. And the cell they gave me, it had a safe in it that the screws did not know about – a false brick and I used to keep all the money and that in there. Then again they said I could use the tattooing gear if I wanted to so I did. I looked in the mirror which is a piece of tin, and you are locked up for 14 hours a day and I just looked in there and did it. Not only that I used to smoke marijuana' (Interviewee B, 23 August 2006).

'Well I mainly just shut myself away from everybody else and just kept to myself because I would go in off the drugs and alcohol and I would feel real shitty for weeks and weeks – takes about three weeks to get back on me feet, maybe four. I was quiet, never had anybody up for anything, hardly smoked. I was getting healthy but once I got into the system and that, and you know they put me with two other fellows and that is when drugs coming back into the scene again. I was laying there for weeks on end, dying and wishing I could get out just for that last hit or something and along it comes out of the blue and the same old thing again. I have tried to get help in there [in prison] for that stuff you know detox stuff and they could not help me because they reckoned my sentence wasn't long enough' (Interviewee H, 1 September 2006).

Interviewee H (aged 26-35 years) has been in and out of Boys' Homes and prisons since the age of 12 years. He was released from prison last in March 2006. His sentences have been six or eighteen months.

Interviewee C makes the following observations about the increase in drug use in prisons since he was first imprisoned in the 1980s to his recent prison sentence in 2005:

'Well, the Corrective Services' system, I think it was better back in the '80s, you know? Prison was a better system back then. Now, in my opinion, it's just gone backwards. The rules have changed. Back in the old days, like, if you had a problem or something you sorted it out there and then. And then after that you went separate ways. These days now, like, people are dying over drugs – for nothing, getting robbed. Back in the old days a bit of smoking, that was Um, marijuana, like, I give that up pretty much years ago. I

think the only time I did touch all that was inside, but that was when I lost my brother and a couple of years later I lost my mother. I think some of the officers didn't mind that. But now you get the pills, you get the heroin, and people are dropping like flies in there. I think, well, in a big way prison saved my life, really. I mean, most of my mates who were out there, now they're all dead from alcohol use and drugs' (Interviewee C, 29 August 2006).

The above respondents were the only ex-prisoners who disclosed they had taken drugs in prison. However, four of the eleven respondents who reported they exercised, kept healthy and came out fitter than when they went in, also reported that they had given up drugs in prison. For example Interviewee A stated:

'They put me on a program and then I weaned off it slowly. I went in there at 54 kilos. I come out as 90 kilos' (Interviewee A, 6 September 2006).

Interviewee L (Interview 14 August 2006) was also healthier when he came out. He kept fit. There were alcohol and drugs in prison but he did not go near them. And getting out was great: *'When I got out I said I was not going back'*. Interviewee L has been back two other times but not in the last year.

8.8 Perspectives of Prison Health Services for the ACT Prison

When the respondents were asked about the health services and programs not currently provided to Aboriginal prisoners they considered that providing a prison-based needle and syringe program was the main issue. Next were services and programs associated with dental health, followed by mental health counseling, counseling for men, education and employment programs, a visitors' program, and a committee to address inmates' problems. In addition, Interviewee D (Interview, 1 September 2006) requested a Koori nurse *'because the boys like to see a woman'*. Lack of optometrist services was also an issue for one respondent who was unable to replace his broken glasses in prison. As a result he had to disconnect himself, went into a deep depressive state, and would not talk to other inmates (Interviewee H, 1 September 2006).

Four of the male respondents had consulted the Winnunga Doctor while in the Belconnen Remand Centre (BRC) or Goulburn Prison. However, the frequency of visits was a concern for three of them. While these consultations had the added benefit of sending messages to families, they were too infrequent to be able to talk over problems. However they valued the Gugan Gulwan Drug

and Alcohol Worker's visits to the BRC (Interviewee K, 14 August 2006; Interviewee L, 14 August 2006; and Interviewee E, 11 September 2006).

When asked about the type of health services and programs which should be provided in the new ACT Prison, they identified the need for needle and syringe programs; dental services; drug detox treatment; a good medical service; mental health treatment; optical services; treatment for those suffering from epilepsy; counseling; Aboriginal staff; family contact and family days; and contact with the Koori community. Interviewee C (Interview, 29 August 2006) was trained by the Prison Welfare to be a mentor to other inmates. This was particularly helpful for young Aboriginal males incarcerated for the first time. Interviewee K provides his views about the services required in the new ACT Prison in the following manner:

'Education and educational courses to help with employment. I don't see much of this in any prisons. Depends on your classification whether there are courses. Plus needles [are required]. If there was a program for needles a couple of years ago when I was in prison maybe I would not have hep C. I got it myself – I made the choice but if they are supposed to be helping rehabilitate myself why can't they They could ask people to put their name down on a list when they take a needle and over a couple of months they would be able to see who is pushing drugs. So they can try to slow it down that way but they can't put a stop to it. It does not come in through workers but through inmates mainly. Numerous people lose their teeth in prison' (Interviewee K, 14 August 2006).

When asked, the respondents were in favour of Winnunga delivering health services to the new ACT Prison. (Not all these ex-prisoner respondents are currently Winnunga clients). One respondent saw this as an opportunity to talk to and network with Aboriginal people on the outside. Interviewee O viewed Winnunga's involvement in delivering health services as follows:

'Better that Winnunga provide these services. They know the medical backgrounds. They have been involved in the injecting drugs side of things in Canberra for quite a long time now. But at the same time there actually needs to be people that have gone through the situation to know what they are speaking about instead of going: 'I understand, I know what you are going through' but have never been sick, never been in prison does not know what it is like to hang out with, so how can you sympathise with someone that's been through it if you have never done it yourself. At the same time Winnunga are great because they do have that understanding but there needs to be that



connection as well. Winnunga would be terrific to go in there because a lot of people love Winnunga and have a lot of trust in them. They do a terrific job' (Interviewee O, 6 September 2006).

Chapter Nine - Aboriginal Female Ex-Prisoners' Perspectives of Prison Health

Drugs and alcohol were the reason for incarceration for both male and female ex-prisoners. Five males and 2 females had also been in children's homes – with male reportings of sexual abuse in childhood. The average imprisonment was 6 months for those aged between 18-39 years. Reasons were petty theft, assault, breaking and entering or breaking parole. This trend follows the prison literature. Recidivism was prevalent in both male and female respondents some of whom expressed the view that prison is not a place for rehabilitation. Older ex-prisoners want to become mentors. Males and females do not cope in prison. Some shut down and do not see their families. For others, contact with families (visits and telephone conversations) is paramount. Females worry about their children who may be accommodated with relatives. Both genders appreciate the support of other Aboriginal prisoners. Aboriginal Liaison Officers are crucial to maintaining family contact and prisoners' welfare. Both genders reported awareness of drugs in prison. Females were more open about how the drugs come into the prison and their fears for themselves (in sexual abuse) and for their family while in prison. Both genders reported concern about safety and self harming which occurs in prisons. Male and female respondents' access to prison health varied – females appeared more satisfied with the service; males objected to long waiting times for services.

Their views on the services which should be included in the new ACT Prison included: a prison needle and syringe program; HIV and hepatitis C testing; dental treatment; health counseling; education for employment; drug detoxification treatment; psychologist/mental health treatment; optical and epileptic help; counseling; Aboriginal prison staff; family contact and family days; contact with the Koori community; and on-call health care. Cultural needs included The Marumali Healing Program which addresses the RCIADIC recommendations and has reduced recidivism in Victorian Prisons, training as listeners, cultural art, Elder visits and music.

9.1 Introduction

This chapter analyses seven personal accounts about female incarceration from the female ex-prisoners interviewed in the ACT/Queanbeyan metropolitan area. It presents their perspectives on the health care they received in prison with particular emphasis on mental health (including the impact of Corrective

Services' culture on mental health), and drug use in prison. It also provides female ex-prisoners' perspectives about the health services to be delivered in the new ACT Prison. Finally, through the perspectives of all the respondents in the study, it considers the cultural needs to assist Aboriginal inmates to better cope with prison life.

9.2 Personal Accounts of Incarceration – Female Ex-Prisoners' Perspectives

The imprisonment rate of Aboriginal women in 2003 was approximately fifteen times higher than the rate for non-Aboriginal women (ABS 2004). Female prisoners in Australia numbered 465 (8 per cent) of the 5,842 Aboriginal adult prisoners in full-time custody for the March 2006 quarter (ABS 2006: 4-5). These statistics are reflected in the small sample in this study of female respondents who had been incarcerated. The seven female respondents in the study had experienced incarceration in the ACT Belconnen Remand Centre (BRC), and Correctional Centres in NSW including Berrima, Emu Plains, Kempsey, Mulawa (maximum security), Norma Parker (Parramatta), and Fairleigh in Victoria.

Three of the seven respondents were in the 18-25 age range and had experienced recent imprisonment as a result of drug use leading to assault, drink driving and theft. Two respondents (one with numerous arrests) had been sentenced to three months each. The third had been sentenced to twelve months and three weeks, had served six months' imprisonment, and was currently on parole. This had been their first prison experience, although two were waiting future court appearances.

The other four respondents were aged between 45-55 years. Two had experienced life in Girls' Homes. Two had been in prison in their twenties and had not re-offended. They had received sentences of two years; and ten years - released after eighteen months, respectively. Of the remaining two, one had been in prison three times (from twelve to fourteen months duration), plus twelve days in the BRC two years ago to cut out traffic fines. The other respondent had also spent four weeks in prison in the 1980s to cut out traffic fines, followed by four years and nine months, for murder (remanded after two years and thirteen months), and six months for drink driving two years ago. Six of the seven respondents disclosed that their life had been affected by drugs and alcohol.

Interviewee P is a single mother and homeless. Her story is representative of the women in the younger age group (18-25 years), and provides some insight into her chaotic lifestyle. She got to be in prison by:

'Just taking money out of bank accounts and drugs and clothes. And when I come out here everything just goes wrong. Hanging around with the wrong crew – drugs, relationships, my kids were taken away. They live with my mum and my sister. They've got everything. They are in NSW (Interviewee P, 14 August 2006).

Interviewee Q is in the same age range as Interviewee P. She has a non-Aboriginal partner of six years who has also been in prison. They live with her family. Interviewee Q received a sentence of twelve months and three weeks (released after six months) through using heroin and committing a crime (unspecified). She was on the methadone program in prison and found it easy not to have heroin. On release she went to a rehabilitation program in Sydney for three months. She was breached by her NSW parole officer for leaving the program to travel to Canberra to visit a sick relative. After a further time spent in a Sydney rehabilitation program Interviewee Q was paroled to the ACT Corrective Services. At the time of interview her parole had been cancelled due to having marijuana in her system and she was afraid of being apprehended by the Police (Interviewee Q, 14 August 2006).

The following story provides an older woman's (45-55 years) experience of prison since the 1980s. The first time was to cut out traffic fines. The next was for murder and the third time (two years ago) was for drink driving:

'I was just over the drink driving range. Well, what I heard, like me parole officer told me that the Judge I was facing, his wife got killed by a drunken driver. That's why he was heavy on me. I went to court, thought I was coming home, and the old chap give me six months. I was shattered. Well, I rung me daughter up: 'Bring me track shoes down and socks'. But in a way I was sort of glad that I was sent to prison, because it got me off the grog. I tell you what, I had a lot of physical health things that was wrong with me' (Interviewee R, 8 September 2006).

Interviewee R provided an insight into her early life:

'We never had electricity or anything. We used to just sit outside and have a yarn to mum, you know, in the dark, and then off to bed we'd go. Yeah. Christmas time we had nothing. Mum used to dress up this little peg, that was

all. Dad used to work up there [Kosciusko]. We moved up there. Very cold. There used to be a hole where you stacked the hay in but it wasn't square, and dad used to put the bales of hay up. And then when he'd buy the paper or something mum used to put the paper on the walls [of the hay stack] and got a big fire going outside. It was good in them days. A lot of respect. [Learned] how to work and that'.

'Dad used to wake us up daybreak to go and do seasonal work in Griffith picking onions. Head down, arse up, you know. And then go home and have a shower and have breakfast, off to school. But it sort of ... it was good in them days. Now geez, I'm bored' (Interviewee R, 8 September 2006).

Interviewee S (Interview 8 September 2006) aged 45-55 years, was in prison in her twenties and has not returned. She got to be there through assaulting her partner ('*trying to rip out his heart*') because he assaulted her while she was carrying her young son. She received a ten year sentence and was released after eighteen months. Much to her concern her two children were put into the custody of her partner while she was incarcerated.

In thinking about the health care they had received in prison one respondent had an understanding of the concept of holistic health. The following accounts provide an indication of the attitudes of females to accessing health care in prison. They communicated these perspectives in a different manner from the male ex-prisoners in that they were more open in expressing their fears for themselves and their family on the outside. Their perspectives reflected the RCIADIC findings that Aboriginal women bear the burden of the community's stress, grief, despair, and alienation. They carry the main responsibility for nurturing the children, and keeping the family together (Commonwealth and State Ministers 1992: 45-49).

9.3 Prison Health Care – Female Ex-Prisoners' Perspectives

New South Wales prison studies have found that women inmates' health service satisfaction is high when an Aboriginal Medical Service provides health services in Correctional Centres (Guthrie et al. 2003). Apart from one respondent who had seen the Winnunga Doctor in the BRC, all other female respondents were in prisons not serviced by Winnunga, although two respondents had received medical (nurses checking blood pressure and cholesterol) and dental treatment from the Daruk Aboriginal Community

Controlled Medical Service at Mount Druitt in NSW. One respondent commented that these visits were appreciated as they provided the opportunity to 'have a yarn'. In addition the Winnunga Doctor communicated with the Correctional Centre about her medical treatment while she was in prison (Interviewee R, 8 September 2006). All female respondents are currently Winnunga clients.

The three younger (18-25 years) respondents' experiences of receiving health services in prison varied. For example Interviewee P went off drugs in prison with the help of valium. She also had pap smears carried out and sought help for a stomach problem and skin infections:

'I had been on the grog for two months straight when they picked me up. I was in a bad state and wanted to get out and when I finally came down and realized there was no screaming and fucking and getting out of there. I had to just stay there until my time was served. You are clean every day. You have to be careful about taking drugs in prison, and fighting. Sometimes blood spills when they cut themselves – things like that. Yeah I was offered [drugs] straight off – just one joint of marijuana. But I just went straight in to Mulawa and I was right – the girls looked after me' (Interviewee P, 14 August 2006).

Interviewee Q was on a methadone program in prison. She had blood pressure, cholesterol and ultrasound tests and commented that *'sometimes they send you away and don't believe you are sick'* (Interviewee Q had to wait two months for her ultrasound test). She considered that the Prison Mental Health Doctor (non-Aboriginal service) was the best person who looked after her health, but was only available for consultation once a month. On the whole the medical help was not available when needed (Interviewee Q, 14 August 2006).

Interviewee T (Interview 15 August, 2006) found that the prison health services were good and she felt better after she received assistance in going off drugs. She exercised in prison and she came out looking fit and well. However, she considered she would have been better served by Aboriginal Medical Service Doctors and Aboriginal Health Workers/Counselors.

Of the two respondents in the 45-55 years age range who had experience of health services in the BRC and NSW prisons until two years ago, Interviewee U (Interview, 14 September 2006) considered that prison had made her stronger after much counseling about her incarceration. She considered that prison health services had improved over time. However, when the Winnunga

Doctor came to see her in the BRC he was not accompanied by a Mental Health Worker whose assistance she required. The other respondent had a heart attack in prison, an operation to put a stent in her kidney (result of alcohol abuse), and had accessed psychological services. She worked in prison on the lawn mowing gang, and in the nursery saving \$18 a week to buy false teeth (costing in excess of \$300 for four teeth). She was able to obtain another set of teeth at no charge when she was in Emu Plains through the Daruk Aboriginal Medical Service that provided health services to the prison. Towards the end of her longer prison sentence she was reclassified and allowed work release into the community prior to her release (Interviewee R, 8 September 2006).

The two respondents (45-55 years) who had been in prison in their twenties, had not re-offended since. One commented that she could have done with health services but no doctors had visited her. She had received treatment from the prison dentist (Interviewee V, 15 September 2006). The other respondent only had the initial health assessment on admittance to prison. She exercised and came out fitter than when she went in (Interviewee S, 8 September 2006).

Similar to the male respondents, some of the female respondents may have been candidates for diversion from the justice system to mainstream mental health on bail, as three mentioned receiving or requiring assistance for mental health problems in prison. Their perspectives of coping with imprisonment are found in the following accounts and were totally children and family focused in contrast to the male respondents' concerns.

9.4 Mental Health and Coping with Incarceration

'Missed me family and being back out in the community – couldn't cope all that well. [Family] crises happened a couple of times. And it got me down but I learned to bring myself back up again. A couple of friends in prison helped' (Interviewee T, 15 August 2006).

'When I first got in there I wanted to get out. I hated it. I knew my kids were alright because I spoke to mum and they were going to be in her care all that time. I did not want to see them [in prison] for the whole three months because it would have made things worse. I kept strong' (Interviewee P, 14 August 2006).

Interviewee V's (Interview 15 September 2006) brother died while she was in prison. She went to the funeral and had to return to prison afterwards. Interviewee U (Interview 14 September 2006) felt emotional when she learnt about family crises in prison but had to hold it in. There was nothing she could do. This was also the attitude Interviewee S adopted:

'I didn't [cope]. On the outside you do but inside you don't because I was a mother at the time – I had my baby and my little boy was so clinging to me.... That has affected my two oldest children. It has affected my kids you know but it has taught them a lesson never to get into trouble with the police. Particularly in their teen-age years - my youngest child is 15 but has no police record. For four of my children I have taught them you are not to ... it is not worth it. I just told them, don't talk to me [about family crises]' (Interviewee S, 8 September 2006)

Interviewee R's account reflects the significant strain in coping with imprisonment:

'I'll tell you what, a lot of women went through a lot of stress. I think women are sort of a special case because they're totally different to men. Men can handle it and they can pump iron, where some women can pump iron and some women don't. They just walk, you know? Yes, they walk around and worry. Yeah, round the complex. I was there one day when I come home from working down the dairy – Emu Plains has got a dairy. I used to do a split shift, you know, milk the cows and then take them out and leave them, and go home, come back to the house then I'd go and work all morning and afternoon. And when I come home in the afternoon, this woman was that stressed out she went in to see the psych, and they thought she just wanted pills. But she said, 'If you don't help I'll kill you'. Well, she did kill that woman. She went back and she stabbed the woman. The woman got away, run, and she caught her again and stabbed her. And that was a bad experience for me, mate. Yeah. The things I've seen in prison. Yeah. And what I seen, you know, when I was in there, I didn't have anyone to talk to, I was on me own. And young ones would yarn just for company with them and have a bit of a talk. Through the stress. Young ones, they were, mm. The first one [who was stressed] was in Mulawa, [a female prison in NSW] and she was a friend of my mate the woman that doubled up with me. She [my mate] went around there all right, she was a hanger. She hanged herself. Yeah. I still have nightmares about it. It's sad. That's why I don't like my kids going to prison' (Interviewee R, 8 September 2006).

Interviewee Q (Interview 14 August 2006) also had suicidal tendencies in prison:

'When I got locked up I threw myself down the steps because I couldn't bear being locked up. You know, I was hitting my head against the wall and hearing voices, anything, I was stuck in this little cell and they wouldn't let me out because I was in drug rehabilitation, suicidal. And no-one still ever come out and seen me. They knew I was like that'.

Similar to the male respondents, the females took comfort in keeping close to other female Aboriginal prisoners. Interviewee V (Interview 15 September 2006) found that Aboriginal women inmates looked after her. They *'stuck together and watched one another's backs'*. When she first went to prison she was scared, and frightened until a friend who was like a sister said she would look after her. Interviewee R (Interview 8 September 2006) enquired how she could move to a section with other Aboriginal women and was told she would have to commit a misdemeanor, so she hit another inmate and her wish was granted. It was Interviewee P's first time in prison and she felt like a stranger in a big prison. However she was comforted by *'the black girls in there keeping together'* (Interviewee P, 14 August 2006).

Interviewee S (Interview 18 September 2006) had a different view of spending time with other Aboriginal inmates and considered they could be a bad influence on her behaviour in prison:

'At first I was in a unit with a couple of sister girls and being sister girls it is real deadly. Then you're stuffed and I don't want to be there because you know what, when my mind starts ... they can take over my mind, and I can be thinking like them and that's what you do. You don't want that screw up – oh no, come on – before you know it you've got a life sentence'.

Interviewee S provides an insight into the safety of female inmates in prison influenced by Corrective Services' culture in the following section.

9.5 Mental Health and Corrective Services' Culture

Interviewee S (Interview 18 September 20) considers that prison is a terrifying place with the fear of getting raped always present. She exercised in prison and thought it helped because the other prisoners were *'a pack of bitches'*. She talked about the rape of an Aboriginal girl with a broom stick, and added: *'Bad enough that the person is inside without this happening to*

her. You have to be there to see it. You go in there with your head up and your guard up – had to have eyes in the back of me head'. Because of the terror she experienced she will not be going there again. She considers that it is impossible for the system to protect inmates from violence unless they are sent to another prison. Interviewee S does not want this for her sons and daughters and has reinforced this with all her children. She was pleased that one daughter was present during her interview to hear her story as a deterrent. She does not agree with locating a prison in the ACT because it will be less of a deterrent in committing crime for Aboriginal youth than the prospect of incarceration in NSW prisons.

The female respondents' experience of contact with families varied. Similar to the male respondents' experience, some families were unable to visit because of the distance and lack of finances for long telephone conversations. Some wrote letters and sent photos to the family. Interviewee T (Interview 15 August 2006) commented *'I missed my family heaps'* and considered that it would be an improvement for ACT residents when the new prison opened. Interviewee V's (Interview 15 September 2006) sentiments on this were: *'When you visit someone it is sad to walk away and leave them'*.

Similar to the male respondents, Interviewee S did not want any family visits: *'I just told them, don't talk to me, I don't want to know about anything and don't bother me, aye, and I should be out sooner than you think, you know. And my children coming in the prison? No way mate. Nope, because I would have been jumping that fence, and I did not want to put up with the sight of my kids hanging on to my legs and screaming and all that nuh, nuh, nuh, nuh. And that's being cruel to yourself and to your children, and it makes the time go harder'* (Interviewee S, 18 September 2006).

Education and rehabilitation programs were available to most of the respondents. However one respondent was concerned about the lack of programs or opportunities to work at the BRC. Four of the respondents performed kitchen and garden duties and packed Qantas earplugs. This helped one respondent take her mind off being in prison (Interviewee Q, 14 August 2006). The programs they undertook included a HIV and health course, literacy and basic education, a church course, traffic control, Occupational Health and Safety Course, preparing menus, Koori conversation and art courses, and sewing classes. Only one respondent had encountered an Aboriginal Liaison Officer in prison, and she considered these visits should have been more frequent (Interviewee T, 15 August 2006).

All of these factors contribute to the state of prisoners' mental health in prison. Wenitong & Daniels (2003: 610) consider that deaths from suicide in prison highlight the importance of investigating the provision of mental health services in prisons, providing cross cultural training for prison health staff in assessing suicidal ideation, and considering social and emotional issues for incarcerated Aboriginal people. This should include providing adequate culturally appropriate counseling and screening and specialist psychiatric services.

9.6 Drug Use in Prison

A study by Day & Dolan (2001) found that Aboriginal people are over represented among injecting drug users in Sydney, particularly females who were more likely to be imprisoned than non-Aboriginal injecting drug users. Wenitong & Daniels (2003) stress the necessity for harm minimization strategies to improve custodial health. This includes making clean needles and syringes available, as well as appropriate methods of withdrawal from illicit drugs and alcohol, and promoting treatment and blood-borne virus testing in prison. WHO (2005a: 5-6) proposes harm reduction which prevents or reduces negative health effects associated with drug injecting in prisons. Prison needle and syringe programs have been introduced into six European countries. The rationale for harm reduction in European prisons is based on public health principles and human rights. As well as introducing needle and syringe programs European prisons follow other prevention programs for reducing drug dependence, which can also be applied for alcohol abuse and unsafe sexual practices.

The female respondent comments about drugs in prisons and unsafe sexual practices were open and frank compared with the male respondents and provide a glimpse into this area of prison culture. For example, Interviewee P (Interview 14 August 2006) stated that during the three months she was in prison she found herself in trouble once only, when she woke up late for muster and had a puff of a joint.

Interviewee Q (Interview 14 August 2006) was very frank about the way drugs come into prison and the temptations to take them inherent in prison life: *'Yeah. They're in there; if you want them you can get them. They [visitors] cut them down ... and they put them in Gladwrap. And then they put them up their bum. Sometimes with stuff like that they pat you [the visitor] down but*

they don't really pat you down around there [the breasts], so you have a little water balloon. You can fit a quarter of pot in a little water balloon. You stick it in your bra and you make it yellow, and you go and buy a chicken pack of Twisties and you get it out and drop it in the Twisties. He takes a handful and he's got it. Scratch yourself and you've got it. You take a handful, drop it in, and he takes a handful and he's got it. They can't see it'.

'Or kids. People come in with kids, they have it in their nappies. I've seen that before. Because kids don't get searched thoroughly, so they have it in their nappies and the prisoner takes a hold of baby and mum, and they get it out of the nappies. I've seen it. There's heaps of ways you can get it in, if you wanted to. And you don't even get strip searched when leaving the visiting area. You just get told to empty your pockets out if you have to, and you go back to your cell. Easy, no worries'.

'In gaol you don't rehabilitate. If you want, you can get drugs any day, all that, if you want. And when you're in there you meet older people who've been in there for ten or fifteen years and you learn new tricks off them. So you come out and you've got new things to do. And so you try them and it works, it pays off. And then you go out and you know more things, how to do crime a lot easier without being detected or And so you're going in there really to do crime school and take drugs. That's all prison is. And you're in there and you take the drugs, what can they do to you – put you in gaol? You're already in gaol, so, you know, who cares? Yeah. It's up to you, [whether you take drugs in prison] but when you're in there you think, Stuff it. I'm in prison, my family's not here, who cares?' (Interviewee Q, 14 August 2006).

This account accords with Foucault's ideas that detention causes recidivism and produces delinquents 'loyal to one another, hierarchized, ready to aid and abet any future criminal act' (Foucault 1975: 267).

On the issue of sexual health, Interviewee S (Interview 18 September 2006) stated:

'Female prisoners should have condoms because the prison officers like the black sister girls. Women need it aye, they do have sexual relationships in there you know, yeah, and I know those chicks have got diseases from each other. Should have a needle exchange and condoms mate'.

9.7 Perspectives of Prison Health Services for the ACT Prison

When the female respondents were asked about the health services and programs not currently provided to Aboriginal prisoners, two respondents thought an Aboriginal counselor was necessary to provide support and check whether the prisoners were interacting in a positive manner with the staff and added: *'the staff treat you like crap and there is no one to talk to about this'* (Interviewee Q, 14 August 2006). The lack of information about prison release procedures as well as programs for women such as art work, and a sewing course to make clothes and toys at the BRC were highlighted as important. When asked about the health services and programs which should be included in the new ACT Prison, the following opinions were offered:

'Maybe mix with other prisons like talking to each other – visiting each other. See what they are doing. Maybe we could do something together. Because there is a lot of talent in prison. I was in there for my good looks. A Dentist would be important. Elders visiting and help for getting out of prison. That's it. I think it would be a white organization providing the services. It would be alright if there were a couple of Aboriginal Workers there but I'd rather see whites because things seem to get done' (Interviewee P, 14 August 2006).

'Better health care when you need it. The Nurses go home at 5pm and if someone is sick at 10pm there is no one only the officers and they have to wait for an ambulance. An Aboriginal girl had a big cyst and she was crying and screaming in pain and it took two hours to get an ambulance to her and take her to hospital. Winnunga would be good to provide these services. It caters for everyone' (Interviewee Q, 14 August 2006).

As well as services provided by female professionals and dental services, there was a significant focus on providing prison needle and syringe programs, and mental health counselors:

'Teach prisoners about drugs while they are in there especially hygiene if they are going to take drugs. There should be a needle exchange' (Interviewee U, 14 September 2006).

'Should have needle exchange and condoms mate. Need counselors. Winnunga could provide a Psychologist not a Psychiatrist – no Psychiatrist should be involved. They gave me a habit – I didn't even have a habit in prison I got my habit when I come out. When you get out of prison you are just free you are happy you are going to do something, you are going to be with your family after

eighteen months, you know. But this prison out here [in the ACT] yeah they definitely need Psychologists for it I think ... any problems explode in prison, and they need counseling. Winnunga should supply this. In this community here in the ACT this is the one thing that non-Indigenous people have got to understand - this is Winnunga, and everybody comes from everywhere here' (Interviewee S, 8 September 2006).

Interviewee S would like to counsel prisoners in the new prison but considers: *'An ex- convict like me would never get a foot in the door like that. Our people aren't gonna listen unless someone has been in their shoes aye' (Interviewee S, 8 September 2006).*

'Need Aboriginal social workers and people from DOCS so when you get out they know who you are. Good to have Aboriginal workers in the Commonwealth and ACT government who provide services. Good if Winnunga provided courses, Aboriginal Health Workers and the Winnunga Doctor, and courses for mental health. A hospitality course would help to get work after prison work' (Interviewee T, 15 August 2006).

'Oh, like the Winnunga Doctor - go in and have a yarn, welcome. I see some of the women, they're just freaked out bad, especially if they're hanging out for that shot. The more female help would be good, because when I was in Mulawa they'd fuck up. And the screws'd get sick of it and they'd shut the whole wing down. The people that don't take that shit, they're locked up too. And the dogs come in; they do whatever they want to do. Winnunga should provide the services. Cause I still see them now and they do a lot for me. Yeah, me sickness and that, and go and have a yarn with problems, they'll come and fix me up. Cause I don't want them to put me back in prison, but I've got a very short wick. Yeah. I'd like to see them put the Dentists in there too, you know. When you're in prison you have got to fix yourself up, hygienic and that, also your looks – and being toothless I found it very embarrassing, because I left me teeth at home' (Interviewee R, 8 September 2006).

These male and female respondents' accounts of incarceration (in Chapters Eight and Nine) reflect the daily chaos and trauma experienced by the Aboriginal community. Atkinson (2002) considers this condition is the transgenerational effects of trauma in Aboriginal Australia commencing with colonial dispossession. At the individual level intense sadness, depression and remorse can be experienced as well as loss of sense of self (Ochberg 1988).

Compounding over generations and growing more complex over time, this pain can become internalized into abusive and self-abusive behaviours within families and communities. Atkinson (2002: 81) believes that the processes of law, social welfare and health care have increased the trauma. For example, there is more dependence on the state and feelings of victimization have been intensified. This has resulted in feelings of powerlessness to change destructive circumstances. The opportunity to be exposed to cultural healing in prison is examined in the following section through ex-prisoners, families of ex-prisoners and prisoners, and support organization representatives' perspectives.

9.8 Aboriginal Culture in Prison

Green & Baldry (2006: 1) consider that the role of social work in addressing issues of justice and self determination for Aboriginal people includes the acknowledgement of Aboriginal ways of working and relating. This prison health study extends these ideas by proposing the term 'holistic care' be used in place of 'social work'. Sharma (2005: 40) notes that the core value of Aboriginal culture is relatedness where cooperation is valued over competition. It incorporates for Elders as well as an obligation to look after one's family and friends; to share money and food; to acknowledge management roles for women; and to recognise the past injustices done to the Aboriginal people of Australia. The introduction of Aboriginal healing programs in prison using Aboriginal cultural knowledge to reduce stress and encourage healing can draw on Aboriginal Australians' cultural strengths and values. Overseas experience of acknowledging prisoners' cultural needs is found in the Canadian Traditional Aboriginal Prison Treatment Program. This allows offenders to achieve mental, emotional, physical and spiritual balance. It also provides an opportunity to develop a sense of self identity cultural awareness, pride and belonging through ceremonies led by Elders (Kassen, 1999: 7).

The Australian Marumali Healing Program is a prison program which heals the spirit and identifies a range of issues. They include social justice, Aboriginal justice, and the RCIADIC findings in addressing the underlying issues contributing to over representation of Aboriginal Australians in custody. From 2001 to 2005, within the Victorian prison system, 178 male and 17 female inmates participated in the Program with 185 prisoners rating it as excellent. Families also benefit from this program because of the resultant change in attitude on release, and the reduction in recidivism amongst the

program's participants. Corrections Victoria has arranged for their Aboriginal staff to participate in the program during 2007. Extending the program to all the non-Aboriginal staff would have merit. Prisoners training as listeners also assists in helping others cope in prison (Representative, Marumali Healing Program, Interviewee 11, 15 October 2006).

Male ex-prisoner respondents in this study reported that participating in prison art classes was the main cultural outlet they had experienced. Interviewee H and Interviewee C had success in selling their paintings overseas:

'Activities for us in prison is more our style. We love to paint, get together, laugh up, paint and all that, sing, get around with the guitars, music, painting. That is hard to get unless you've got a guard that is organized with that stuff. We had a gallery lady up there who used to haunt me every day and night with boards and paint, making sure everything was right, and I would paint and would sell them for about \$80 or \$90 – that was the price. But whatever she was making who knows, but she would be back half an hour later saying 'Come on do me another one right now. I need another one'. And bang, she would be gone. They are all overseas now my paintings – I never got to see one of them. I do not paint now. It's too much ... using alcohol at the moment' (Interviewee H, 1 September 2006).

'You're going to get brothers in there and sisters in there who paint, and they have something ... have somewhere where they can set their art out and sell it. Yeah. With the prison system, you know, I made over \$20,000 on painting. Most of the paintings went to the prison gallery. All the money I had, I sent home to my wife for the kids and to buy furniture and all that. I worked it out, all you get out of it was, if you sold a painting for \$600, you'd get \$500. Doing those paintings, selling myself short, you know, but all the money I made I'd send home. I'd keep a friggin' couple of hundred dollars' (Interviewee C, 29 August 2006).

The male respondents also recognised the spiritual assistance provided by Elders visiting prisoners. Interviewee C (Interview 29 August 2006) recalls that it helped him just to be in the storyteller's presence. However, only six male respondents had experienced visits by Elders. Other prison cultural activities were visits by Aboriginal dance groups and opportunities to learn Aboriginal languages. Both male and female respondents had experienced visits by Aboriginal bands during the National Aboriginal and Torres Strait Islander Day of Celebration (NAIDOC) week. This was appreciated as

an important cultural event, along with raising the Aboriginal flag at the Belconnen Remand Centre during NAIDOC week.

In general, the male and female ex-prisoner respondents had not had ready access to Aboriginal media such as the *Koori Mail* and the *National Indigenous Times* in prison. The only regular cultural activity reported by the female ex-prisoner respondents was art and pottery classes. Their experience of visits from Elders in the community was similar to the male respondents, although Aboriginal visitors from Redfern would visit Mulawa Women's Prison to discuss prisoners' issues. The female Elders in prison passed on their stories and Interviewee R recalls:

'You'd find that you might be telling a yarn, and you'd talk about a certain person. Well, that person might know that person. You know? There's that many common links. Yep. And I'd be telling people how I grew up' (Interviewee R, 8 September 2006).

The family perspectives about exposure to cultural programs in prison were similar to the ex-prisoner perspectives. One family member noted:

'They will share paintings and tell little stories about what they did when they were younger but not too many of the young lads know much about their culture' (Interviewee BB, 7 September 2006).

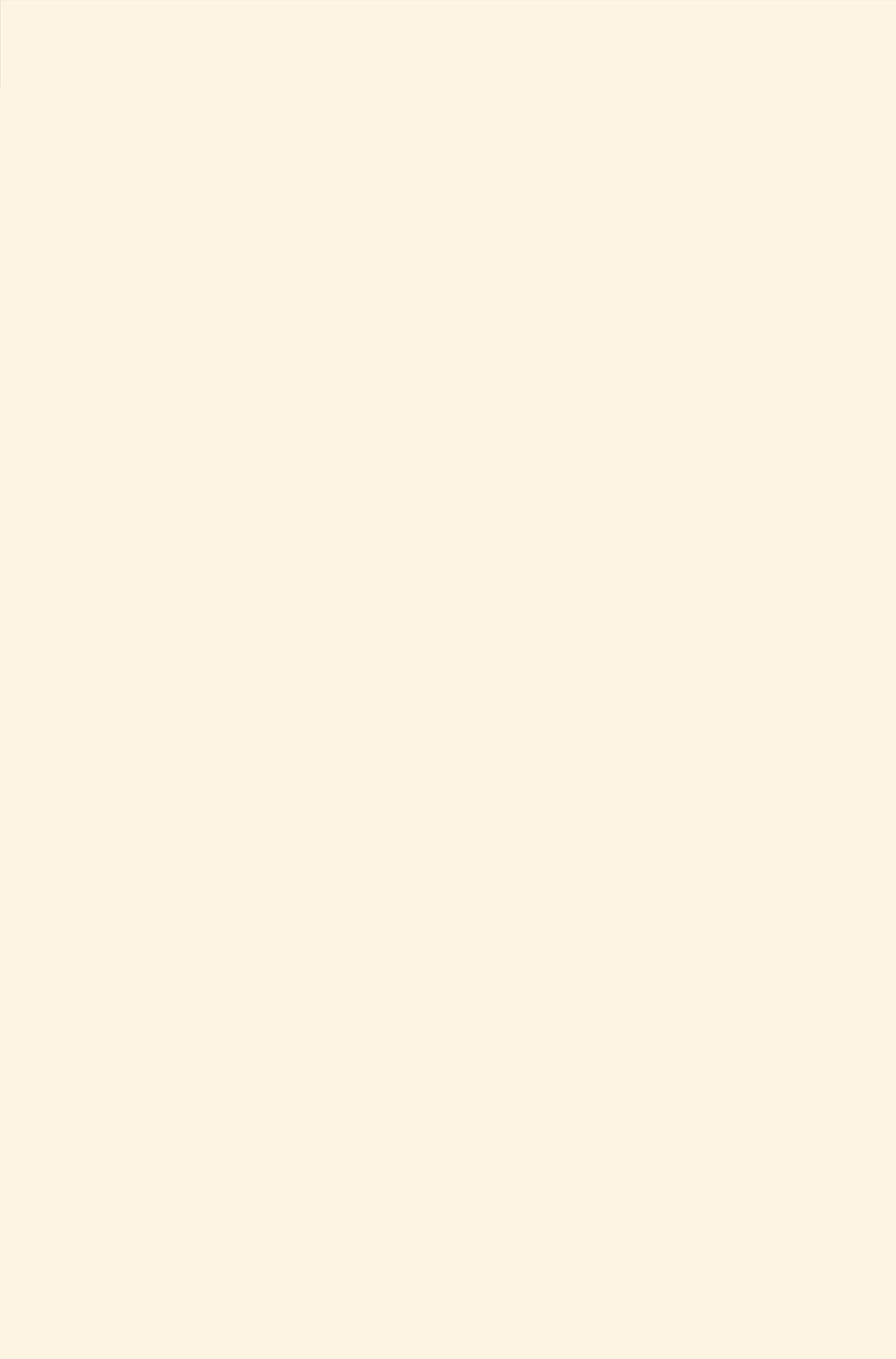
Another family member reported that the monthly visits from the two representatives of the Queensland Aboriginal Justice Committee (a RCIADIC initiative) to report on prisoners' welfare was a good initiative. This provided their family members with regular opportunities to 'sit and talk' with community members, which helped with the stress of incarceration (Interviewee CC, 8 September 2006).

Overall, the ex-prisoner and family respondents considered there was a need for the Marumali Healing Program in prisons, as well as sporting activities; music - playing the didge, clap sticks and guitar; story telling; film making; spiritual teaching; having a yarn; Aboriginal culture courses; Aboriginal pastoral visits; and the opportunity to receive assistance from an ACT bush healing rehabilitation and detoxification farm (currently under consideration) on release. Some family and support organization respondents were concerned about the difficulty in developing a cultural training package suitable for people from different Aboriginal Nations. They considered that generic cultural programs would be preferable to guide the participant to research

their own culture (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October; Interviewee AA, 25 August 2006).

Support organization respondents named the following cultural activities which should be incorporated in prisons namely: creating an environment where prisoners live their culture – for example, the NSW Aboriginal prison work farm where prisoners work in fisheries and horticulture; Elders visiting daily to yarn over damper and coffee; a prisoners’ peer support group; ACT bush healing rehabilitation and detoxification farm; meditation; the Marumali Healing Program; Aboriginal culture and custom awareness training for prison staff; Link-Up to trace prisoners’ families; cultural programs to provide a sense of identity and respect; computer knowledge; literacy and numeracy training; ex-prisoner mentor visits and:

‘Being proud of the culture – art. Art in the prison grounds – a salute to Aboriginal culture. Feeling you are part of it and acknowledgement around the culture built into daily practices. And rituals that will make people feel valued – like the Islamic religion’s daily structures’ (Aboriginal Parole Officer, ACT Corrective Services, Interviewee 12, 4 October 2006).



Chapter Ten - ABORIGINAL FAMILY PERSPECTIVES OF PRISON HEALTH

Family members consider that their relatives do not cope well in prison. However, they believe that the support their relatives receive from other Aboriginal inmates helps. Families communicate with their relatives in prison via visits, telephone conversations and letters. Families struggle economically traveling to prisons for visits, staying in overnight accommodation, and providing their relatives in prison with money to use the telephone. Some respondents were not aware of financial assistance from Prisoners' Aid to visit relatives in prison. The chances of visiting relatives in prison decreases when they are incarcerated significant distances from the ACT. Relatives experience an added financial burden when caring for female inmates' children prior to obtaining Centrelink assistance. Should the arrangements for the children of inmates who are accommodated with relatives not be appropriate, the risk of their becoming homeless, not attending school, or turning to crime increases. Similar to ex-prisoner respondents' accounts, the family members consider their relatives come out of prison much healthier due to experiencing a stable life (away from the drug culture on the streets) with regular meals and exercise. Extreme stress is experienced within the whole family when a death occurs, particularly if the incarcerated family member cannot attend the funeral. Winnunga outreach services for ex-prisoners and their families for mental health and drug and alcohol related problems were considered essential. Health services required in the ACT Prison include: fast response to methadone requirements, drug and alcohol programs, financial assistance for family visits, education courses, drug and alcohol counseling, dental care, compassionate Winnunga Health Workers, qualified Winnunga Mental Health Workers, male and female Winnunga Health Workers, Aboriginal Liaison Officers on 24 hour duty, and social justice for prisoners.

10.1 Introduction

This chapter synthesizes the data gained from interviewing 17 family members of prisoners (5 male and 12 female) in the ACT/Queanbeyan metropolitan area. Ten family member respondents are related to the male and female ex-prisoner respondents in Chapters Eight and Nine. Their accounts are identified separately in this chapter, as they complement their relatives' (ex-prisoner) accounts of prison health including mental health and drug use. Other family member respondents introduced new perspectives to the

study. As well as considering Research Question 2 (see Chapters Eight and Nine) this chapter also addresses Research Question 1: *What are the health and cultural considerations of delivering holistic health care services for Aboriginal inmates in the ACT Alexander Maconochie Centre?*

10.2 Family Member Accounts of Prison Health

Five female family member respondents had an understanding of holistic health. The extent to which male and female family members were aware of how their relatives were faring in prison varied. This was highlighted in the different accounts about how their family member coped with incarceration, the health services and education courses/rehabilitation programs they accessed, and the assistance received from prison Aboriginal Liaison Officers. Foucault (1975: 268) considers that ‘the prison indirectly produces delinquents by throwing the inmate’s family into destitution’. These respondents’ accounts reflect the hardships encountered in coping when a relative is incarcerated and the assistance they may have received from Aboriginal and non-Aboriginal organizations. Some families have needed to relocate from the ACT to towns in NSW to be near their relative in prison. The following accounts are from family members of the ex-prisoner respondents in Chapters Eight and Nine. Double alphabetical letters denote family respondents’ accounts, and a single alphabetical letter denotes ex-prisoner accounts.

10.3 Family Member Accounts – Relatives of Ex-Prisoner Respondents

The following family members’ interviews have been summarized with some verbatim accounts included.

Interviewee DD said that at first her partner, Interviewee N (aged 26-35 years) did not cope in prison and was not happy. After phone calls to her he was happier. His cousins were in prison at the same time and this helped him. He looked after his health well in prison and was able to obtain all the health care he needed. He was able to talk to her on the phone whenever he needed to. The Welfare Officers also helped him. One officer was Aboriginal. Phone calls were important because she could not visit her partner when he was in a Sydney prison because of lack of overnight accommodation. Interviewee DD would have had to stay overnight, as she is not a good traveler. The same applied when he was in Goulburn Prison. She would have been able to visit with more support and lacked family support. It was difficult. She did not get

help from Winnunga. Her partner came out in better health because he was off alcohol and doing weights and eating a lot. He gained a few certificates and did a rehabilitation program (Interviewee DD, 11 September 2006).

Interviewee EE stated that it was '*a bit hard*' coping when her partner, Interviewee L (aged 26-35 years) was in prison. She was unable to visit him. Consequently, she considered that families do not know what is going on in prison. Help with travel is very important. Overall, Interviewee EE did not receive much support when Interviewee L was in prison. A visit from an Aboriginal worker from the prison would have been helpful – just to check if she was alright. This would also help communication between prisoners and families. Her extended family helped when crises occurred, and Winnunga also helped in these instances when she approached them. There were times when she was unsure how Winnunga could help but found out through word of mouth (Interviewee EE, 14 August 2006).

Interviewee LL is the non-Aboriginal partner of Interviewee Q (aged 18-25 years). He visited Interviewee Q in prison every weekend and she wrote to him. She found it expensive to ring him in Canberra from Emu Plains, Penrith in NSW. Interviewee LL is aged 26-35 years. He has spent 6 months in Junee Prison and 1 month in Goulburn Prison. He did not ask for help with his health from Winnunga or from Prisoners' Aid to visit his partner, and did not work while she was in prison. Going to visit each week meant he had to sacrifice a lot of things because of finances. His health suffered – he lost a lot of weight. It took it out of him but she needed him. He received a lot of support from Interviewee Q's family (Interviewee LL, 14 August 2006).

Interviewee FF and Interviewee C reside in country NSW, but Interviewee C (aged 36-45 years) was incarcerated in prisons around Sydney. He coped quite well, as Aboriginal people support each other in prison. He is a talented artist. He painted in prison and sold his paintings overseas, and they were able to buy furniture. His health needs were met in prison. The prison Aboriginal Liaison Officer (her cousin) rang Interviewee FF to let her know when he was moved and assisted Interviewee C in telephoning her through the prison office. Interviewee C phoned her if he had money in his account. He did many education courses and received certificates. He did counseling courses and became a qualified counselor. He would worry about what was happening at home. She would only tell him things he would have to know about. When his son had an accident Interviewee C was allowed to visit him. This helped Interviewee FF cope with the situation.

Interviewee FF continues: *'It wasn't very nice while he was in prison. I could not see him'*. It was very hard economically. Centrelink helped out mainly. Being alone was hard. The time went quickly looking after the family (children and grandchildren). Corrective Services in Sydney were helpful and if she needed any help they provided it, for example, money to travel to see him. She visited him whenever she could i.e. every fortnight or every month. She used the pension passes on the train but they expired. She traveled by train at night to visit him in prison. Interviewee FF arrived in Sydney at 7am had all day with him and caught the train back at the end of the day. She arrived home at 2 am next morning. When he was in Lithgow she had to stay somewhere cheap over night – at the weekend. The Aboriginal Health Service in NSW where she lives helped out with her medical requirements. Travel money to visit him would have helped instead of taking money out of Centrelink payments (Interviewee FF, 29 August 2006).

Interviewee GG was 4 years of age and Interviewee MM 3 years of age when Interviewee S, their mother, went to prison 20 years ago. They have maintained a strong brother and sister bond. Their father had care of them. Interviewee GG:

'We knew mum went away but no one told us for how long until one day she showed up out of the blue. But the abuse we put up with from our father because of what mum did to him and he couldn't get at mum so he took it out on us a lot. Me and my brother would be sitting there watching TV and he would walk into the room and hit us. There was no sexual abuse.'

Interviewee MM: *'We forgive him today and that. Like we sit down and say good-day dad and talk but we can't go back to when we were little kids and talk about it. I told him 'I forgive you but I will never ever forget', I said 'I love my mum'. My mum and my dad they are good friends today – that's what gets me'*.

Interviewee GG: *'My brother is 21 this year and from the time he was taken from mum while she was in prison he has not been the same little boy. He still has to have counseling over it'*.

Interviewee GG translates her feelings when their mother was incarcerated to her own children's welfare. She tells her partner if he has to go to prison again she knows how their boys would feel in missing him. When her children asked where their father was when he was in the BRC she told them he was

working. Interviewee GG did not want them to know about prison. However, if he goes to prison again she would now explain to her boys and take them to prison to visit him, and warn them that they will end up there should they commit crime. (Interviewee GG and Interviewee MM were taken to prison by Interviewee S to see their uncle in there as an example) (Interviewee GG and MM, 11 September 2006).

Interviewee HH is Interviewee P's (aged 18-15 years) and Interviewee T's (aged 18-15 years) grandmother. She went to court with Interviewee P and gave a character witness which shortened her sentence to three months. Interviewee P's mother looked after her 6-year-old, and her sister looked after her 2 boys (aged 3 and 4 years).

Interviewee HH: *‘Three months was good at the time as it got her back on track for a while. When she came out of prison she tried her hardest to make a go of it for the kids but she had been away from them for too long. She wanted to be a free woman – a single young woman. It is hard to see them go to prison but it is harder to see the kids without their mums. That is what hurts me – asking where their mother was’.*

Interviewee HH cried when Interviewee P received a 3 month sentence. She told Interviewee P to ring her if she needed anything. That was the only support she could give. She worried because she was on drugs and alcohol before she went in and they are available in prison.

Interviewee HH: *‘Interviewee P was well when she came out. She was good in prison. She never got into any arguments and when she came out she was really good. A lot of people need that’.* Interviewee P was under the Doctor at Emu Plains Prison, and when she was released they chased her up because she had a health problem, and she followed it up with the Winnunga Doctor. Interviewee P did education study programs in prison. (Interviewee HH, 15 August 2006).

Although Interviewee T had been incarcerated in Mulawa (see ex-prisoner accounts) Interviewee HH only spoke about her times in rehabilitation centres in Wollongong and Cowra, each of eight weeks' duration, where she had been directed through the Court system. Interviewee HH reared Interviewee T. When she went to rehabilitation it hurt Interviewee HH more than for Interviewee P, because she has been around Interviewee T all her life. Interviewee T has two

girls and it was hard for them and for Interviewee HH, because she looked after the 6 year old while Interviewee T's mother looked after the younger one. The 6 year old was asking where mum was all the time. Interviewee HH tried to explain but the child would cry. (Interviewee T had separated from their father 6 months previously). Interviewee HH found it extremely difficult providing for the child prior to receiving Centrelink financial assistance. Winnunga had a lot of input when Interviewee T went to rehabilitation. They rang up on her behalf and looked after the health of the children.

Interviewee HH: *'I couldn't believe it – Interviewee T was one of the wild ones. I've seen her hit the grog but I've never seen her so well when she came out. Interviewee T and Interviewee P both try. Interviewee T is trying to get back on track with the girls'* (Interviewee HH, 15 August 2006).

Interviewee II and Interviewee NN are Interviewee R's (aged 45-55 years) children. Interviewee R has been in prison three times (see ex-prisoner's account). When she was imprisoned for 2 years and 13 months Interviewee II and Interviewee NN were 18 and 14 years respectively. Interviewee II did not want to relate how her mother got to be in prison at interview. She found it difficult looking after herself when her mother was in prison because she was by herself and traveled everywhere. She did not know where her brothers and sister were. She noted that Interviewee R seemed sad in prison but put up a front to Interviewee II and a brave face. Her mother consulted doctors in prison but her state of health did not improve. Prison Liaison Officers made it easier for the family and her mother, and helped to obtain Prisoners' Aid for Interviewee II, her father and aunts to visit her mother. Interviewee R would ring her aunt, and they would arrange to visit her the next day. Her mother worked in prison and on work release. She also did art work and pottery which Interviewee II has kept (Interviewee II, 1 September 2006).

Interviewee NN adds his perspective: *'It was a bit hard – pretty hard you know [when Interviewee R was imprisoned]. I did not want to live with me father. It was no good – all four of us children, so we stayed with an auntie. We didn't like it there and then we went and stayed with our nan and the two girls liked it there, but me and me brother went our own ways – living on the streets and getting into crime and bad things like that back in the day. It was a bit hard. We didn't have any income. You know we had to ... well, I went and stayed with an auntie and uncle and they put me on an income, Centrelink income. I stayed with them for about two years then I come back up to Canberra. Got*

into bad crime and violence. I was picked up then and that is all part of the way. I got a family now to look after, responsibilities and that, so’.

Interviewee NN has never been to prison. However, he stole a car to visit his mother in prison. His other brother Interviewee K, has been imprisoned – see ex-prisoner account. Interviewee NN continues:

‘And I wasn’t going to school after me mother sort of left me. Well she never left me, she got put away that was it. Even if I went to school the other kids would talk about me mum, you know what I mean, and that would probably set me off to be violent towards them. That’s why I did not worry about school. When mum came out of prison we all got together in a house in Canberra – the four kids and mum was there’.

‘Well, the last time she went to prison [two years ago] it was a surprise for me. I went around looking for her - did not know where she was. By the time I went around to the Police Station she was half way to Berrima Prison. Last time in prison mum coped alright. When I visited her she seemed alright coping with grandchildren running around, and when visiting time was over we were told we could come back the next day or next weekend or something. Because when you are in prison your mind starts running away with you, you know’ (Interviewee NN, 1 September 2006).

Interviewee NN commented that Interviewee R received health care in prison, took her heart tablets, and received a set of teeth from an Aboriginal Medical Service. She did art classes and made pottery (Interviewee NN, 1 September 2006).

The following family member respondents are not related to the ex-prisoner respondents in Chapters Eight and Nine. They introduce additional prison health and family coping perspectives into the study. These accounts are summarized as follows.

10.4 Family Member Accounts - Not Related to Ex-Prisoner Respondents

Interviewee OO (aged 18-15 years) was unaware of a lot of the details of his father’s incarceration. He thinks he is currently in prison and has been there 4 or 5 years to date – his longest sentence for stabbing someone in a hotel. It was drug-related. He has been to prison many times, the shortest

sentence being 3 months. When Interviewee OO was small he had contact with Aboriginal Welfare Officers but not now. They arranged phone calls at his school with his brother and sister to talk to his dad. Now he is with Centrelink who are hard on him sometimes. Life is difficult for Interviewee OO. He has not seen his father or his siblings for a long time. He is tired of not having accommodation and being homeless and is now living with Interviewee R (ex-prisoner respondent) who is putting him on the right track, and will find out if his father is still in Goulburn prison. Interviewee OO goes to Winnunga some times when he gets sick and also goes to a Queanbeyan (non-Aboriginal) Doctor (Interviewee OO, 14 September 2006).

Interviewee CC's partner (aged 32 years) has been in a Queensland prison twice - initially when he was 18 years old when he received a 7 year sentence and paroled 4 years and 6 months later. He received a sentence of 5 months the second time. Drugs and alcohol were involved leading to break and enters and assault with a weapon for the longer sentence. Interviewee CC met her partner in between sentences. In addition he has been in the BRC a few times for several weeks but was not sentenced to prison. Interviewee CC observed that in prison her partner just wanted to get out and back to the family. He had the support of Aboriginal inmates and from family and friends as well. But he did feel stress because Interviewee CC was pregnant. He kept good health in prison. The Aboriginal Health Service from Rockhampton visited him. His mother died while he was in prison and the prison helped him to go to the funeral. He thinks prisoners should not be told about what is happening outside. They need to be told about deaths but not their wives having another relationship, because the prisoner's reaction to the latter information determines whether he wants to go back to prison or not.

The last time in prison he came out in good health as he exercised. He did some courses and received a forklifting certificate and a driving licence. He was not on a methadone program. Interviewee CC was pregnant when he went back to prison the second time and it was difficult not having him around. She had to take a half hour trip to visit him in prison. It was supplied by the Aboriginal Health Service in Rockhampton which also passed on messages to her. She did not have a phone to communicate with him. Interviewee CC said that her partner was able to find work on coming out of prison the last time. He has changed dramatically and work has played a large part in his rehabilitation. He is a responsible young man now with a family. He did it himself with support from his Parole Officer (Interviewee CC, 8 September 2006).

Interviewee BB was interviewed with her daughter-in-law, Interviewee JJ (aged 18-25 years). They provided family perspectives about their son and partner (aged 26-35 years). Interviewee JJ's partner was in the BRC at the time of interview. He has previously been in prisons in Goulburn and in Sydney. Interviewee JJ explained that her partner got to be in prison *'through the influence of friends – they follow like sheep. Drugs and thieving, to get the money to get whatever they need and keep going'*. In Goulburn they are with the brothers and older Aboriginal males. Her partner had dental work done in prison. He is healthy in prison from eating, working out, no drugs, being on the methadone program, and is in better health on release. He has completed drug and alcohol, and anger management courses and received certificates in prison. Interviewee JJ commented that her partner thinks the courses are good but she thinks they do not seem to work on him. She thinks it is better not to tell him about big issues happening in the family – only little things. However, family members should tell prisoners about a death in the family. She is not sure whether he has had contact with a prison Aboriginal Liaison Officer.

Interviewee JJ stays around the family rather than venturing out in the community. Her in-laws are very supportive. There is more contact when her partner is in a NSW prison because she finds it hard to get to the BRC in Canberra with the children on the bus. Visiting him is a problem. She does not feel comfortable visiting at the BRC because she has to spend an hour with him and worries about the environment and cannot concentrate on the visit with other people there. Visiting Goulburn Prison is also difficult with a baby and having to stop to feed her on the way. Interviewee JJ has received \$80 a fortnight for petrol from Prisoners' Aid to visit her partner. Prisoners' Aid also provides train tickets but they have to be used for visits. This is not enough for a place to stay. Receiving assistance with accommodation would be helpful. Winnunga provides assistance to Interviewee JJ. She has medical check ups for the children but not necessarily for herself. However, she considers that Winnunga could have helped her in traveling to Civic to Prisoner' Aid to collect the money they pay each fortnight for the prison visits. When visiting she also requires money to bring cigarettes, sweets, and drinks to her partner (Interviewee JJ, 8 September 2006).

Interviewee BB said that her son (Interviewee JJ's partner) is in the BRC *'because he did not comply with the order to report to the Police and they suspected him of doing other break and entering around the place. They have*

been chasing him for a while. He could be looking to do a prison sentence. Although the probation officer asked me what I would like them to do, and I said I would like to see if they could get him into rehabilitation instead of sending him to prison. He has been offered rehabilitation before and I can say that he didn't stay very long, he walked out from Karralika [drug rehabilitation] in the ACT'.

It has been difficult for Interviewee BB when her son has been in prisons in NSW because she did not have photo identification to visit him. She added: *'But I had his family living with me the whole time. This was my job, really [to look after the family]'*. When he was in Goulburn Prison she did not have the money to visit him as his partner, Interviewee JJ was accessing Prisoners' Aid funding for travel. She added:

'We all live not far away from the new ACT Prison, although it is a bit of a walk if you had to walk it, but not long in a car. I reckon it would be good to have it here. At least you know you could go and visit them without any problems. Poor old Interviewee AA [Interviewee BB's sister] had to drive to Goulburn with the daughter-in-law and the grand daughters to visit her son, and sometimes other relatives go too, and it is a long trek to go there and back'.

Interviewee AA and Interviewee BB are members of the Nannies' Group (see Chapter Twelve) which works towards supporting community members while in and out of the justice system. Interviewee BB thinks her son coped alright in prison:

'Well, as far as I know I never ever heard anything different. I think that is because he knew a lot of other people in there. But I would not have a clue about how he looked after his health. He never spoke about it'.

Interviewee BB considers that the Aboriginal Liaison Officer at the BRC is excellent and cares about the young males in there. When considering the state of his health when last released from prison she said:

'He came out looking a lot healthier than he did when he went in I can tell ya. They all come out looking nice, and down the track it is just back to the same things. I don't know whether he went on methadone when he was in there. He wouldn't get on it in the BRC; he refused to take it. He did not say he was on methadone but he looked nice and healthy when he came out. He also did weight training'. She added: 'I have signed him over to my sister, [Interviewee AA]. He is a bit of a pest'.

Interviewee BB did not seek support from Winnunga or any other organization when her son was in prison. She just received support from the family (Interviewee BB, 7 September 2006).

Interviewee AA provided a family member's perspective about her son's (aged 26-35 years) time in Goulburn Prison. He is currently serving a prison sentence of 2 years and 2 months. Interviewee E (see ex-prisoners' interview) is also Interviewee AA's son. She has experienced the deaths of two other sons through a drug overdose and a suicide by hanging (not in prison). The following account provides Interviewee AA's perspective of how her son got to be in prison:

'Well, first off he's an addict. Drugs are pretty rife among my sons - all of them. Not that I'm saying that the drugs caused him to be this way, because he's been doing naughty things for quite some time. He's had ongoing matters to be dealt with, and he had been in Bennelong rehab for three months in both cases. So all up he would have done six months, although it wasn't the full six months. And then he reoffended, and I think they decided it was time he went to gaol. He was my youngest boy and he was in Quamby when he was 11. He was doing quite a few things, but what got him into Quamby was the fact that he was with another young child and they actually burnt someone's house down. I'm not sure of the circumstances of how it was done. I think he was given nine months. And it was a school day so I didn't know about it until the Police had him in custody. He was supposed to be at school. So that's when his custodial time started, from 11 years of age. Apart from the Quamby episode at 11, basically it's just all been burglary or breaking and entering' (Interviewee AA, 25 August 2006).

Interviewee AA's account of how she copes when family members are in prison identifies the importance of community support.

'It's a bit harrowing for me when I have more than one in custody. I'm coping okay now with my son being in there, but that's because he's the only one and I can focus on just the one. But when I had two or three in at the one time, I was all at sea. I didn't know where I was going. And I did not receive any support from anyone. I didn't even know at the time that I could get help from Prisoners' Aid. This would have taken a lot of stress off me. I used to pay my daughter-in-law's mother to take me, and that used to come out of my own pocket. It was costing me quite a lot of money when I had my boys in prison. On top of paying for petrol to visit, I also had to send them \$30, or if there was more than one of them there I'd send a bit more. That was basically for

them to have contact with me, so that I knew that everything was okay. And they do contact me’.

Interviewee AA continues:

‘My son had a big setback when his brother died, because he was in prison and because of his classification he could not come to the ACT for his brother’s funeral. I asked him if they get to see anyone from Winnunga, and he assured me that they do. The Winnunga Health Worker does go up to see them. To know that is comforting for me. When he rings me and the occasions I’ve gone up to see him I have the impression that he does not believe that he’s lost a brother – there’s no closure for him yet. Because he wasn’t allowed to attend, he didn’t see his brother in the coffin. When he talks about his brother, he talks of him in the present tense. Then he’ll remind himself. He said to me ‘I can’t quite believe, mum, that he’s gone’. And that’s something that the Winnunga Health Worker needs to work on with him. These are the sort of issues that I want dealt with in the prison while he’s still there, because he’s still got a long life ahead of him. I don’t want him to come out and suffering trauma because I’m not sure that he’ll get any assistance from Winnunga’.

‘I’m not going to pat Winnunga on the back for the good work that they’ve done, because there’s still a lot of work to be done and they need to do it. They’re accountable to the community; we’re not accountable to them. They’re up and running because of people like us. You look at the services that they say they provide – mental health workers, alcohol counselors. They should do outreach. Not every drug addict is going to walk through their door and say, ‘I’m sick. I was on drugs and I’m trying to withdraw’. And people who are severely depressed are not going to do that. Some people can’t get out of their homes when they’re severely depressed. I’m trying in my own way to do the right thing for myself, for my body and my health and wellbeing, but mentally I don’t know how long it’s going to take for me to crack. And I don’t know if I’m ever going to carry out my thoughts and go up to the tree and do what my son did [hang himself]. But Winnunga doesn’t see that. Winnunga doesn’t ring me up and say, ‘How are you feeling today?’ They all rang when I lost my son but that was it; that was the extent of the calls. And this is what my cry is, that they need to follow up on people’s wellbeing. Even if that person is not able to come in they need to get out and see them’ (Interviewee AA, 25 August 2006).

Interviewee AA is concerned that ACT prisoners in NSW prisons do not receive the same privileges as NSW inmates:

'The ACT prisoners in the NSW prison system do not receive the treatment that NSW prisoners get because they are funded by NSW; they are not going to treat prisoners from other places. You will find the same with Queensland prisoners, because some of them transfer to NSW prisons. The ACT prisoners in NSW prisons miss out on quite a lot, for instance medication. They weren't obliged to give my son medication because he was an ACT prisoner and he was prescribed in the ACT. So there is that really big issue, and I'm not sure how they fare right around NSW, because I dare say there's a lot of ACT Aboriginal prisoners throughout the NSW system – not just in Goulburn and Junee'. (Interviewee AA, 25 August 2006).

Interviewee AA provides an insight into the importance of attending to prisoners' mental health problems and diverting them into the health system instead of the court system:

'I think their physical wellbeing was pretty good, because they generally all go to BRC first. They do their toning up until they get back to court and get sentenced. But I think by and large their physical wellbeing has been okay. For my sons, it's always been their mental condition. And it's drug induced. They haven't been well when they've gone into the BRC and through the court system. And this was noted on quite a few occasions by the Magistrate, and so they get an assessment done'.

'This is something that's lacking. I know that the Winnunga Doctor goes out to the BRC. I'm not sure that the Winnunga Health Worker ever did. Before I lost my son I went out to the BRC with the Aboriginal Justice Advisory Council people and we went through the whole system. They showed us different sections, and they showed us where they keep people with mental health issues. And I know that one son was in there. I know that another son was in there. And they said that all they can do is put them in there and keep them separate from the rest. They get Doctors in to see them, but they can't do any more than that because they're not experienced. And they can't just call them out to the BRC and take them over to the [hospital] psych unit. So their hands are tied, but they've been trying for a long time to stop getting prisoners in with mental health issues. A lot of the people in the BRC at the moment are in there because of drug induced behaviour. If the officers at the BRC can't do anything, what can we parents do? And they have to stay there

until they go back to the court, and have assessments done. They probably get reports from the officers at the BRC. But I'm not sure how much the court weighs up their mental health problems and their ongoing activities outside the prison' (Interviewee AA, 25 August 2006).

Interviewee AA considers that the BRC Aboriginal Liaison Officer helps the ACT Aboriginal community in significant ways, but more assistance is required by the community in support of mental health problems. Unfortunately, she has not found the same assistance with the newly appointed Aboriginal Liaison Officer in the Goulburn Prison.

'[The BRC Aboriginal Liaison Officer] doesn't just deal with the Aboriginal people, because she actually works for Corrective Services. But, she does bend over backwards at times, and I know she's a fiery little customer, and she'll get up and have her say. So it's good that she's there, but she is not a trained medical person either. I mentioned to her on the day that we went out to visit the BRC, I was concerned about my son. I said, 'There's just something not right with him. I don't know how I can deal with it'. She said, 'Oh aunt, he was fine in here. He just needs to grow up'. And three weeks later he was dead. And I think she really regretted saying that to me. But she's just like me; we're not trained to see things. All I can see is that my sons aren't right. I don't know how I'm going to help them. And this is where people like Winnunga should be getting up and doing more for the community, doing outreach work' (Interviewee AA, 25 August 2006).

On the subject of how her son copes with family crises in prison Interviewee AA comments as follows:

'Well, I tended not to tell my boys anything. However, I couldn't not tell my son about his brother. So deaths are always something that we tell them about, because I think they'd get pissed off if they didn't know that one of their closest relatives had passed on. But any feuding or if I suddenly discovered that his partner was having a fling here and there, I would never tell my son. I would never, ever tell him. I wouldn't tell him even when he came out. That's something that somebody else would tell. And if you know the black grapevine, it'll get around, but it won't come from me. So no, I don't tell him anything that's going to affect him while he is in there. I will tell him if there's happy news. Just recently my older son got married and that was a happy occasion. And he'll see photos of that. But anything that's going to affect his time in custody I won't ever discuss with him' (Interviewee AA, 25 August 2006).

Interviewee AA provided her perspective about a prison needle and syringe program:

'They're in there [drugs]; if you want them you can get them. Well, we can't do anything about the prisons already established, but we can put some weight into what's happening as our prison is being built, and I personally feel that the screws need to be more scrutinized such as having the same strip searches that happen when you go to the BRC. A prisoner could be getting something from his wife. But if the aim of this prison is to rehabilitate all prisoners, whatever reasons they're in for, and a lot of our prisoners will be in there from drug induced problems, then my own personal opinion is that a needle exchange is not going to serve the purpose, because it's defeating the purpose. Well, it is, because if you want them to rehabilitate and get away from all that crap that has caused them to be in there in the first place, why have a needle exchange? But that's just my opinion. This is why there's so many Aboriginal people in prison who have problems with hep C, and HIV. How are drugs getting in there'? (Interviewee AA, 25 August 2006).

10.5 Perspectives of Prison Health Services for the ACT Prison

While four female family members did not know whether important health and wellbeing services were provided to their family member in prison others (3) thought their relative received all the services they needed. One female said her partner did not receive important health services in the BRC – this was related to delays in obtaining methadone. Another commented about a two month delay in her husband receiving diabetes medication at Long Bay Prison. Lack of assistance in visiting relatives in prison and with overnight accommodation, and ACT prisoners in NSW prisons not receiving an equivalent health service were further concerns.

Interviewee NN – a male family member – considered that as well as education courses, young males need to be assisted in coming off drugs and alcohol and to be put off going to prison by learning about it:

'Koori groups in prison to get the same things as out here like narcotics anonymous and drug and alcohol anonymous. Get that in the prisons, you know, maybe they might slow down on drugs and alcohol. I got a cousin in prison and he has been in and out of prisons since 1982 through drugs and alcohol. You are so long in there you get institutionalized and you know the routine in there. If you grow up on violence you know nothing else but violence – so the drugs and even the health [services] Boys might need

scaring a bit you know these young Kooris trying, you know, to earn their stripes and knock off a car and going to prison and earning their stripes. It is not right you know’.

‘Should have Koori groups teaching them reading and writing because half of them Koori blokes don’t know how to read or write. Get them maths, like back to school again. Scare them – scare the young blokes. Get the young blokes together just going in there – they put their chest out you know what I mean and tell them what it is really like in prison – mentors or just a group telling them about the old stories about the missions they grew up on’ (Interviewee NN, 1 September 2006).

While two female family members were unable to suggest the type of health services and programs which should be incorporated into the new ACT Prison, appropriate visiting arrangements, dental treatment, Winnunga services, including women medical professionals, counselors, and Aboriginal Liaison Officers on duty 24 hours a day, and qualified Mental Health Workers were considered paramount by other respondents. Interview CC’s (Interview 8 September) concerns about the new prison were related to prisoners’ social justice. She related a story about a prisoner attending a funeral with his hands handcuffed behind his back. He could not wipe away the tears and the community had to beg his guards to free his hands. Interviewee BB expressed her immediate concern about the state of her son’s mental health and the services which need to be available in the new ACT Prison. He is currently in the BRC.

‘Need good Mental Health Workers to go out and see them. Someone who has training because we don’t know what their mental state is when they are locked up. When my son goes to Lithgow Prison he probably will have a problem because being on the drugs and that, he will be really stressed out and I don’t know how he goes. But at the moment because he has been in there [the BRC] for a while, I think he did have a bit of a detox period there because he wanted to fight the guard at the BRC. But I spoke to the Aboriginal Liaison Officer the other day and she was on her way to see him and the other prisoners as well, but she assured me he was OK. If she has other problems she has my number and can call me. Winnunga should provide mental health services for them. As long as the person is qualified to do it. Because you can’t have any one going in there asking questions because the prisoners won’t feel they could talk to that person. They need someone Aboriginal they could talk

to and tell their problems or whatever is affecting them in prison or about family life or whatever’ (Interviewee BB, 7 September 2006).

While conducting interviews with representatives of organizations which support prisoners and their families (see Chapter Twelve) this study found that ACT Mental Health is adopting a new policy to ensure that the Aboriginal Mental Health Worker from Winnunga accompanies non-Aboriginal ACT Mental Health professionals when they conduct sessions with Aboriginal prisoners (Director, ACT Mental Health, Interviewee 31, 31 October 2006).

Interviewee Q had some misgivings about the prison health and wellbeing services which might be provided by Winnunga in the new prison:

‘Just probably being a bit quicker, and not being judgmental as some of them are. Just in general. Most of the workers that work for Winnunga, I mean, are judgmental. Some of them are not as committed to helping you as they should be. I find they - when you ask them to do something they pass it off. They don’t look into the situation as much as they could. Oh yeah, I’ve often felt that, and I’ve had to basically do most of it myself. If you’ve just got a help with someone who can They’ll give you support, but it’s just not enough. You need a support person. Yeah. Just the organization that’s going to do the best for you would be OK, I suppose. I can’t say which one that’s going to be, but as long as it’s the one that is going to help the prisoners the most, whether it’s Aboriginal or whether it’s not’ (Interviewee Q, 25 August 2006).

The following chapter examines the health and wellbeing support currently provided by Winnunga and other organizations to ex-prisoners and their families on release from prison.



Chapter Eleven - ABORIGINAL EX-PRISONER AND FAMILY PERSPECTIVES OF SUPPORT ON RELEASE

Preparation for release and assistance on release are necessary to curtail the cycle of incarceration and the desire to return to a place that is safe and predictable. The most important requirements on release are accommodation and employment, and social and emotional support. These are not automatically arranged as part of the release process. Support is required at the prison gate on release with assisted travel to hostels, home units or housing (with assisted living and outreach services provided). In addition, assistance is required with reintegration into the family and community, obtaining identification papers and in communicating with Centrelink, work training and employment, parole commitments, and medical, mental health, and drug and alcohol requirements. Particular attention is needed to gaining knowledge about employers who will employ ex-prisoners. Assisted accommodation would also provide accommodation for families who are visiting relatives in prison. Mentoring assistance in prison and on release is best delivered by people who have experienced prison, and drug and alcohol addiction. This is also a way of building a sense of identity and self esteem. Family support on release is also important. Increased service implications for Winnunga include increased outreach in the community, detoxification and withdrawal from drugs and alcohol, professional mental health and wellbeing assistance, and counseling. Other support organizations recognized by the respondents as providing support were: Boomanulla Aboriginal Oval, The Connection, Gugan Gulwan Aboriginal Youth Corporation, NSW Family Services, Woden Hospital psychiatry, Tuggeranong Health Centre (mental health and counseling), Centrelink and the CDEP.

11.1 Introduction

This chapter examines ex-prisoner and family member respondent perspectives of the support received on release from prison. These issues are also examined in the accounts provided by support organization representatives in Chapter Twelve. Both chapters address Research Questions 2 (previously stated), and also 3 and 4: Research Question 3: *What are the health service implications for Winnunga Nimmityjah Aboriginal Health Service?* and Research Question 4: *Who are the other organizations involved in providing services, and the communication requirements between these organizations?*

11.2 Health and Wellbeing Support on Release

Of all the issues discussed by this study's respondents the requirement for assistance on release from prison was most prominent. Additionally, some male ex-prisoners identified two other issues associated with release. They are the anticipation and fear of release; and the desire to go back into prison to a place that is safe and predictable. Interviewee H and Interviewee J's accounts below, explain these sentiments. (Double alphabetical letters denote family respondents' accounts, and a single alphabetical letter denotes ex-prisoner accounts).

'Every day the sooner you get out the longer the days get. That's the worst; that's when stress and everything really hits ya – the fear of getting out once you get settled. You get used to one place and it's just like being kicked out of a home. You sorta just got used to know the run of the things and how to get by and live in there. And when it is done, bang it is all over, you are out on the street, you've got nothing again, nobody to rely on, and you are on your own and you've gotta do things from scratch. I've got no place to live at the moment. I'm on the streets. Got a wife and two kids, and I've got nothing I can do to help them because I've got no place or a roof over my head to settle down in' (Interviewee H, 1 September 2006).

Interviewee H's next court appearance was imminent at the time of interview. He added:

'I might be moving into prison again for 18 months, then I can finally settle down. I am still a loose cannon, I don't know when I am going to go off'.

'The 21 months I was in prison I had one visit in that time from a mate living in Tamworth. That was good, because it gave me hope. I am at the end of my sentence and I am going to end up doing time outside but you seem to stop and think what's life going to be outside. You get outside well I've known a lot of blokes who did something stupid that they shouldn't have done, but when they end up leaving they don't want to leave because they don't know the world outside – they want to come back inside because they have got all their friends and all their mates and everything inside. And the screws are not like father figures, they are like mentors. All the screws you get to know over the years they can really help you out but sometimes in the wrong way. If you need something on the outside they can sniffle it for you, you know. They can always check up on you late at night. They come into the cell and they look if you are allright' (Interviewee J, 1 September 2006).

Interviewee J recounts experiences the day of his release:

'I got me \$600 and the first thing I went to the cop station. 'I just got out of prison; can you take me down to the train station?'' As I was driving past I went and seen the pub – the train station was just down from it. I booked me ticket and it was about two and a half hours before I had to catch the train back to Queanbeyan. I went back up the pub and got rotten drunk and had to walk back – well walk half way. It is a big relief – it is a huge relief. It's like ... when you are in prison the thing you really want to do is do the things that put you in there, and you are not part of that, so you go to the pub and get drunk and you are back there again. I've know blokes that have done it. Prison is not like a correctional centre – it doesn't correct you. It makes you harder and angrier' (Interviewee J, 1 September 2006).

When Interviewee C was released from prison his wife (Interviewee FF, Interview 29 August 2006) traveled to Lithgow with their granddaughter to meet him. The house where they usually stayed was closed and they had very little money, so she was faced with staying at the railway station. Some people helped her to find a place to stay at an Aboriginal Co-operative. Interviewee FF described her feelings when she saw Interviewee C on his release as 'so happy'. They all traveled on the train back to their home. Interviewee C provides his perspectives on being released from prison:

'In prison, like, your last week of your sentence, that's where you get your half a dole cheque from. And just, after I walked out that gate and got dropped off at this train station, after eight years, I mean, like, half a dole cheque, that's not much. But also when I went to prison I was a big man, and leaving prison eight years later I'd lost a lot of weight and with the little half a dole cheque I didn't have any clothes that fitted me. The clothes I got at home were too big for me'.

'If you're doing two years and under, like, yeah, it'd be good to come out to a job. But doing a big lag, you know, you're on your own, you just come out. Because all you're doing is just walking. You're seeing brick walls every day and bars and everything, and the yard, because I mainly walk on me own. I mean, going shopping – I left [prison] the Friday morning; we travelled all the way home from Lithgow by train. I said, to my wife 'I think I've got the courage to go shopping with you'. As soon as I walked into all the shops I said, 'No, take me home'. You know, it just blew me away. I never left the house for weeks after that' (Interviewee C, 29 August 2006).

Interviewee E stayed with his mother on release and comments on the overall lack of assistance available to ex-prisoners on release:

'Just got the release papers and that was it. There is no help for people released from prison. You get your release payment [from Centrelink] and that is that. When you get out of prison you've got nothing only the clothes on your back that you went in with. It is terrible so you've got to start all over again' (Interviewee E, 11 September 2006).

Others were homeless on release:

'Not even Parole would help me in there. I asked them for housing assistance and all that. They went yeah, yeah, bang, bang, chuck me out the door with half a cheque. They said get out your time's up, out you go here's your money – see you next time. \$220 they gave me – that was it. I was disgusted about the money and I nearly ripped the lad's head off. I wanted a bit more than that, and he said that's all you're entitled to' (Interviewee H, 1 September 2006).

'I got no support and walked out to nothing – not a flat or somewhere to go to' (Interviewee P, 14 August 2006).

'I come out to nothing, really. I come out to my family's place [where her partner was staying] but I felt like, I don't know, a lot different. Like, I've been in prison so I'm not worth nothing. I won't really get a job, I've got prison on my thing, I can't work with kids, I can't work with the elderly. What's left? Nothing, really. A Macca's job behind the counter? Because I've been done for fraud I won't get a cash register job or nothing. And I thought, stuff it. Why? Take drugs and sell drugs, I'll get paid more. You know?' (Interviewee Q, 14 August 2006).

11.3 Settling Back into the Community on Release

The respondents' experience of settling back in the family and community since release varied as the following accounts demonstrate:

'Nowhere to live. It is hard coping. I am just stressing out thinking when am I going to have my place, when am I going to get settled down, but I can't. I've no ID to help me, no ID, no nothing and when you get out you are starting from scratch, and I still ain't got 100 points to get on the housing list. And they reckon they do all that from prison and I am still on their computers. I got no help from prison' (Interviewee H, 1 September 2006).

'Personally I found that good because I just went back into the community and 'Where have you been?' 'I've just got back from New Zealand man'. A bit of bullshit goes a long way. I got back into the family but I still needed help, so then I would go to Prisoners' Aid. I did not like explaining myself again to a white person. Even now I go to Centrelink and I carry on to them as if I am still dumb. They fill in my forms and show me a different attitude to what they would do to someone who has learned. Like with housing a Winnunga Health Worker helped me get a house [government house] and we went to housing for them to pay my bond and two weeks rent – they would not do this. The Winnunga Health Worker brought me back to Winnunga and I phoned my friend who paid it for me in 10 minutes. And I don't have to pay him back because of favours I have done for him over the years' (Interviewee B, 23 August 2006).

'No problems with that – just settled back into my family. And the community I stayed away from [because of peer pressure to go back to using drugs]' (Interviewee O, 6 September 2006).

'Settling in was good but needed time to be back home' (Interviewee N, 8 September 2006).

'Been OK – starting to settle back in. I am just glad I am not on heroin any more. I am doing the right thing. I haven't got a job or anything. The Winnunga Doctor writes me out sickness certificates for Centrelink' (Interviewee E, 11 September 2006). Interviewee AA (Interview 25 August 2006), said her son (Interviewee E) leaves the house to see the Doctor at Winnunga or to visit the Tuggeranong Mental Health Centre. She keeps a close eye on him in the hope that he will stay off the drugs.

Interviewee C reflects on the surprises he encountered in his first contact with life in the community after being incarcerated for eight years:

'Being home with the family's all right. It was just taking a step outside. It was eight years, like. The trains and that, yeah – I was at a train station at Central there, and I went to buy food. I only bought two pies and a sausage roll and a bottle of drink, and he wanted to charge me \$15. I said 'Shove it mate'. I mean, all that stuff would've cost about \$6. Yes, I'd like to see Welfare more involved for the brothers and sisters, especially if you're doing eight to ten years. When you get out there, should be that support there for them. Like, at least Welfare could pick them up and take them in to the Salvos, some of those

places. Accommodation for those who need it' (Interviewee C, 29 August 2006).

A Nunkuwarrin Yunti Aboriginal Medical Service Doctor in Adelaide observes that most studies about the health of prisoners focus on improving prison health services. However attention to health and social and emotional wellbeing in the community play a significant role in reducing excessive incarceration and recidivism. Crucial factors considered necessary for Aboriginal people on release from prison include: 'housing and tenancy support; mental health and wellbeing, including family violence, grief and loss support; substance misuse support; general health services, including hepatitis C management; and social inclusion, including the need for family and community integration, skills development and employment' (Krieg 2006: 534).

The following section examines the respondents' experiences of finding work on release and their perspectives on the assistance support organizations can provide to stop recidivism. Within the male and female ex-prisoner respondents' population only four males were in the workforce. Interviewee J who lives and works in the bush provides his account of finding work on release from prison:

'It was a little bit hard. Like well you just got out of prison and the people seem to think you were in prison, so you are a lot harder now, and they are stand off, and they don't know how to take you, and you are just glad to be out, and you want to be out with your friends and your family. But then you get into a circle the vicious circle that you once were in and you get back in'.

'But when you get out – I just spent all this time in prison but what am I going to do when I get out? No one is going to want a bloke to work for them who they know that has stolen a car – they don't want that. When I got out of prison I got a job on a property. [The employer] found out that I did time. I was only there for about 7 weeks and he said 'No good, sorry see you later. I don't want you pinching my tractor or my truck and selling it'. It was like everything was still settling in, like I was still getting to know meself because my mum never told me anything. She never told me that I was a Koori. She never told me that I had an Aboriginal father'.

'I would rather have the flat fences [in the bush] instead of the walls. It is as a result of being through what I have been through. I isolate myself from the human race because I don't know what is going to be around that next corner' (Interviewee J, 1 September 2006).

Interviewee F (Interview 8 September 2006) went back to his wife and family on release and found work straight away making pizzas. He had worked in the prison kitchen doing the washing up. However, it was too soon and he could not handle it. He felt as if he was back in prison although he was earning a wage. He is currently on a Centrelink personal support program to assist him to obtain work.

When Interviewee K was released at times he would *'walk around, when I moved back with my mum, with chisels in my jacket – weighing about 2 lbs. That was the way it was, my mentality. If I wanted something I would take it'*. The Connection has helped him on occasions *'but we don't get as much help as we would like. Counseling would help and a program for when people come out. You have to wait for a house unless you put in for it at the start of your sentence. A hostel would help where people could go and be safe if they don't feel they want to go home, or a rehab would be good for brothers like myself'*.

Interviewee K has not been in the workforce since 1998.

'Need a Job Network member working on the inside for inmates advising they have jobs for ex prisoners – looking for the right person for the right job. Could stop a person from reoffending again. I am on the path where I am trying to fix myself up now. I am 29 and I still find life hard. I think about going back to prison just to have time out sometime because I can't have a life on the outside. It is hard. Basically you just need just some sort of support system there for younger people so they don't end up where I am today'.

Interviewee K would like to be a mentor for young people coming out of prison and The Connection would like him to work with them but he needs to pick himself up first. He is coming out of a state of depression from breaking up with his partner. He hasn't seen his daughter for 6 months.

'I know I could go to work but I have got a pretty bad criminal record – not that that will stop me. I haven't been in trouble now for nearly two and a half years, besides a couple of misdemeanors. The more support from the Aboriginal community, the more better' (Interviewee K, 14 August 2006).

As previously noted in Chapter Eight, there is a strong desire among the male ex-prisoners in the older age group to work for the benefit of the community in teaching culture and art work to school children, and volunteering in the

mental health community sector. Interviewee C has counseling qualifications which he gained in prison, a newly acquired driving licence, and with the assistance of his parole officer and a NSW AMS he has formed a Men's Group. He provides an account of his experience as a mentor:

'Well, I'm actually in a men's group. I drive there once a week and just rekindle the spirits. There's a lot of blokes there my age and a bit older, but the young blokes can go now. What I mean by rekindling the spirit is there's blokes who have been molested when they were kids. I mean, I was a nipper myself at the time, you know? And it's just learning to cope with it and talk about it. It's been a long time ago but it's always there, you know?' (Interviewee C, 29 August 2006).

Interviewee P (Interview 14 August 2006) and Interviewee Q (Interview 14 August 2006) also expressed their desire to obtain work. On considering life in the community Interviewee Q thought it would be good to have someone who trusted her and to help her in obtaining work instead of coming out thinking that:

'No-one's going to trust me again. Like, anyone hears you've been in prison, then they look at you like Yeah, there is [life outside prison]. But we don't know how to go about it. I've known drugs since I was 13. I don't know nothing else but drugs. So I don't know where to even start to try and better myself, only that I had thought maybe volunteering might get me into working, so I thought I'll start there. But before that I had no idea, none. I still really don't today have an idea where I can go, what am I going to do. I have to take it day by day, minute by minute, really' (Interviewee Q, 14 August 2006).

Centrelink Prison Liaison Officers (Interviewee 30, 24 October 2006) work in conjunction with the Chamber of Commerce in placing ex-prisoners in the workplace. For example, they recently placed two intellectually handicapped ex-prisoners in a Goulburn organization which works for Art Unions and provides gardening and mowing services and pre-posting work, such as filling envelopes and preparing flyers. The experiences of the ex-prisoner and family respondents in this study do not reflect the optimism shown by Centrelink in locating work for ex-prisoners. They all emphasized the difficulty ex-prisoners have in joining the workforce. The only positive work experience for several male ex-prisoner respondents, which kept them out of prison, was their employment over a few years with a landscaping company. Unfortunately, the owner traveled overseas, had a heart attack, and

the company closed down. Interviewee JJ's (Interview 8 September 2006) partner worked for the landscaping company until it folded. She comments on the cycle of incarceration. Her partner was in the BRC at the time of her interview:

'When he comes out it is all good at first couple of months – he thinks he is the father of the year and the best partner and everything going. Then he mingles with the people down the road and goes back to the same cycle all over again'.

Interviewee O, another former landscaping employee considers that:

'Prisoners need to be set up 100 per cent before they get out. Even have job opportunities waiting, some employment, even have courses, already have them enrolled in courses. They need to start thinking about what has to be done because they are just coming back and doing the same stuff and going back to prison. The majority of people don't have that family support – they are from broken and unsupported families. There needs to be more programs set up to help the boys to be able to make that transition from prison to life and to try and break that cycle of mucking up or just to get them past that parole period – at least they have a better chance of not going back to prison if they knock that parole off their head. And if they do make fresh charges that is another thing altogether, and then they have to go back in front of the courts. It is not straight in front of the Parole Board and the Board goes 'That's it, you are going back go prison'' (Interviewee O, 6 September 2006).

11.4 Community Support on Release

The experiences of the respondents in this study follow Krieg's (2006) findings on Aboriginal ex-prisoners. They emphasize the importance of integrating social and emotional health perspectives as fundamental components of health service delivery and family support on release from prison. However, some respondents stated they did not ask for support, and were reliant on themselves and their 'brother boys'. Others received support from playing touch football at Boomanulla Aboriginal Oval, The Connection, Gugan Gulwan Aboriginal Youth Corporation, friends, the Woden Hospital Psychiatrist and counseling, NSW Family Services, Centrelink for welfare payments, and CDEP for work. Interviewee G (Interview 1 September 2006) expressed many respondents' sentiments when he said it was easier *'to speak to a black fella organization'*. Ex-prisoners and family respondents' experience of receiving support from Winnunga on release from prison were in the areas of:

- Maintenance work on the garden;
- Doctor's certificate about obtaining housing and an ID;
- Assistance with mental health, drugs and alcohol problems;
- Health problems;
- Health problems for their children;
- Social and emotional wellbeing counseling;
- Psychiatrist consultations; and
- Petrol money to travel home to northern NSW.

However, they reported they would have liked increased services from Winnunga in the areas of detoxification, drugs and alcohol, and mental health outreach services. Interviewee AA provides her perspectives on the benefits of outreach in the community as follows:

'My son goes to the Tuggeranong Health Service for his counseling sessions – or they come to the house. Actually, they do that more often, come to my home to see him. But sometimes they'll tell him that he needs to catch a bus down. And he does it. He's really good about it. But mostly they come to my home. And that's probably on occasions when they want to speak to me, because I don't go with him down to his one-on-ones with the counselor. He does that himself. He could work that way with Winnunga as well'.

'If she [the counselor] has a one-on-one with him, then she'll come and talk to me and ask me about how I'm feeling, and if I can see any progress in him. She doesn't tell me what he said, and she doesn't tell him what I say. But he and I already know. We discuss things between us. And I always tell him, 'I'm going to speak to your counselor, and this is what I am going to tell her, because you need more assistance'. And he'll say, 'Oh well, you can tell her that if you want'. And generally he'll agree to things. But he's appeasing me, and what I want is for him to be doing it because he wants to get well. But the counselor knows that. And then she'll sit with us both and then she'll talk to us about the issues surrounding the both of us, and how she'll set about doing something. There is a Psychiatrist at the Tuggeranong Health Clinic or he may be a mental health professional. My son has meetings with him as well'.

'My son won't be medicated by them [at Tuggeranong]. He comes to Winnunga to get medicated. And I think there's something wrong there, because he has a drug problem and it should be widely known. And so I'm not sure that what he's receiving here [at Winnunga] is conducive to his health, and whether it's setting back the help that he's receiving from the other place. And I've weighed

all of this up because I can see what's happening, and I think that if people want to have Winnunga as their place of treatment then these people have to come to the party and start looking seriously at what people's problems are, and not be quick to hand out medication. My son needs serious counseling and he's not getting that at Winnunga. And this is where I have an issue with Winnunga. It's not because I don't want Winnunga to be ... I'm really glad this place is up and running and it's good for a lot of people. But they need to look at what they're doing with regard to different mental diseases. And mental health issues are serious in this town and very, very common in the Aboriginal community and getting worse. I'm not bagging Winnunga, but as a concerned mother I have to voice my opinion, because I need to know that my kids are getting the best care that can be given, and if they don't have qualified people to do it, it's not going to happen' (Interviewee AA, 25 August 2006).

The ex-prisoners and family member accounts in the following section provide perspectives on how support organizations can manage the cycle of incarceration.

11.5 Recidivism and Community Support

The male and female ex-prisoner perspectives were similar in that they believed people had to make a personal choice to change and to want to help themselves before any positive results would happen. They also considered that the best people to provide help were those who had been through the same problems. The male ex-prisoner respondent views follow:

'There is a heap of a difference coming to Winnunga rather than a general health centre. They don't care for an Indigenous person as much as an Indigenous centre. I came to Winnunga when I got out. I come to Winnunga for psych evaluation not the hospital because I will get the same treatment at Winnunga, and at the hospital I will have to wait a long time. It would be better if Winnunga had an officer to contact the prisoner the day before they got out and explained it all to them - what to do when they got out' (Interviewee K, 14 August 2006).

'Giving courses for skilling for jobs. Having programs people can do. People would rather come to Winnunga to do programs rather than doing them somewhere else. Skills for getting licences would be an example' (Interviewee L, 14 August 2006).

'Organise work release to go out during the day and go back to prison at night' (Interviewee G, 1 September 2006).

'Yeah, The Connection can do this because when clients come in, right, they look at The Connection workers and the workers, like they're helping us but they have lived their life and they are doing the same thing as we are doing even now, except not thieving and that. And occasionally like having a bit here and there you know what I mean. Clients feel comfortable with talking about their problems, their issues. They love using the services and being referred to rehabs wherever, and they are comfortable about it, whereas normally any other time if The Connection was not open they would not speak up. They do it the hard way and ever since The Connection has seen a lot of Indigenous people, especially people we grew up with. They have changed and we are changing, you know what I mean' (Interviewee A, 6 September 2006).

'When people breach their parole – people like Winnunga can't help unless you are going to waive the parole breach, because it is a personal choice. Unless they start making that choice to stay out of trouble for a period of time they are just going to keep going back to prison. Because no one helped me I had to help myself. You have to stay out of trouble for yourself. It is more the Corrective Services who have to help about parole. Winnunga can help by putting programs in place but it is a Corrective Services' job, and it is the goal's responsibility to look after the prisoners, and they do a shit job at it – they don't care what you do in there as long as you are not seen and not heard and the majority of screws get paid. There are drugs in prison no matter what they tell me. How these people are getting so much drugs in there, is the majority of them are getting paid. They have shitty paid jobs anyway. Well I know they are all corrupt anyway' (Interviewee O, 6 September 2006).

'The Connection is one example of help. To give them options before they get to that point. And it is a personal choice they need to make. Do they want to go back to prison or do they want to do something about it. The majority want to do something about it, but there is not much out there for them to help and this is where The Connection comes in because clients can see that the workers have had drug problems and been in and out of prison and stuff like that, and they can see that change is possible and it is not that hard and you can do it. Especially with the methadone program and the buprenorphine program and rehab. The drug problem is not that bad because you can lead a stable life on the methadone or buprenorphine and you can get off that but

the majority just don't stay on it. They are too wrapped up in the money side of things or the drugs. They just don't care about what is happening. They are too wrapped up with their drug problems or with their girlfriends and stuff and forget about what is important. Your girlfriend is important but so is your freedom and your health. And I would prefer to stay out of prison than to be running off and carrying on and worrying about ... I know my wife is right; she does not do the shit. But I know a lot of the boys' women add pressure by running around and using drugs and sleeping around and it just adds pressure to what's happening' (Interviewee O, 6 September 2006).

'Got nothing to do with organizations – more with to do with people keeping themselves out of prison. A bit of work would be good, on the CDEP or anything doing for Aboriginals to keep busy' (Interviewee N, 8 September 2006).

'Sit down one on one and listen to them. Yeah, like, if someone sat down with me I'd say, well, this is what I want to do, but this wouldn't happen straight away, because have to get re-used to the community. Maybe in a couple of months, I can do this. And like, 15 months now I've been out. The last 12 months, the only thing I can say is I got on with my art work, I've had my first exhibition, plus I got another exhibition of my art work next year. Done a fair bit [painting] years ago. But in the last four years I've been actually sold overseas, so I'll leave a name for myself, you know?' (Interviewee C, 29 August 2006).

'Could help with accommodation when released' (Interviewee M, 30 August 2006).

'Need jobs. The government is not helping in any way whatsoever because money is a big problem for everyone. You get outside and you don't know what is going on so you have to stop and think what is it that you A person who is to be released from prison even if he did 21 months – let him do 10 months, let him come outside and give him counseling for 12 months. Once you are outside you feel like a bird released. It is just like trying to encourage people – people have their own mind to do what they want to do. The one thing I want to say is that the Kooris are very family oriented – they love their family and once they get out, 'Hey I am home free' (Interviewee J, 1 September 2006).

'You have to pick a certain minority of people who want this and want that,

and need this and don't need that, but you've got to understand that a lot of people, a lot of young people who get in there are scared and they want and need to see their family more. Even how heinous a crime they have done if they can have contact with that family they can talk to that family, and they can feel happier and they could feel a lot better. Even like human contact – not the mongrels sitting in those 15 feet walls. But there is a lot of people in there who are really, really scared and they come out and they repeat again. They fight back against that system that put them in there in the first place. They come outside then they re-offend' (Interviewee J, 1 September 2006).

'Outside the hostels and refuges there is not a great deal of places for people to go to when they come out of prison. The majority come out with a quid in their pocket but once they hit town that could go in two days depending on the amount' (Interviewee D, 1 September 2006).

The importance of family support expressed in the male perspectives was also reflected in the female ex-prisoner respondent views. Other concerns were the need for outreach work by Winnunga and lack of accommodation on release which can encourage ex-prisoners to return to drug taking.

'People just put themselves in prison I think. Drug and alcohol workers help a lot of people, but people have to help themselves. It is really hard to help someone when they don't help themselves. When I got out I had nowhere to go, nowhere to live. I never had any help while I was in there. I wanted to get out of prison and go straight into a flat or something you know, and there was just nothing. That is why I turned back to drugs because I never had no home to depend on. Like even a flat or something, and I just had no help with that' (Interviewee P, 14 August 2006).

'Not sure – Winnunga does their best and supports people pretty well. More regular home visits with counselors would be good. You can't get picked up and taken to Winnunga for a chat about the methadone treatment any more. They would also take you back to your house before' (Interviewee Q, 14 August 2006).

'Winnunga does not have enough respect from this community. They need to be harder on the community – they are giving them too bloody much. That's how they bloody run amuck. And you know what, the people who are really trying in this community are the ones missing out. Winnunga needs to open their eyes and their ears. Take notice of the people, take notice of their problems

that's what it is, taking notice of your people aye, and not judging each other' (Interviewee S, 8 September 2006).

'Drug and alcohol outreach, physical [medical attention], and a worker at Winnunga from Housing once a week' (Interviewee T, 15 August 2006).

'Oh well, it's just up to the person themselves. They've got to help themselves first, before anyone else can help them. And with Winnunga outreach, it'd be good. Yeah. But if you're a person who never ever drunk – like I found in the system, this woman, she was a drug and alcohol worker, she'd never took a drink in her life. She read books, learnt that way. I said to her: 'You don't know what you're talking about'. I said, 'You need to go through it and then you know what the person's talking about'' (Interviewee R, 8 September 2006).

The family members' perspectives of support organizations' roles in helping recidivism also included the benefit of community and family involvement, the value of outreach in the community, contact with ex-prisoners on release and the potential of the newly formed Aboriginal Justice Centre to assist with these issues.

Interviewee OO's father is in prison (see his account in Chapter Ten) and he is homeless. When asked how support organizations can help in keeping people out of prison he commented that Interviewee R is helping in this way, because she has offered him a home with her family. He also thought that detoxification centres, counselors, and assistance with finding work would help recidivism (Interviewee OO, 14 September 2006). Interviewee II's (Interview 15 August 2006) observations were that her family member had received strong support on release from prison at a rehabilitation centre, and from the family. This had introduced her to community gardening. Interviewee FF (Interview 29 August 2006) considered it was important that Aboriginal Medical Services contact ex-prisoners on release to offer support. Other family views were: *'Winnunga could have a workshop in prison – Koori art or pottery. After prison would be good to still do art. Exercise is also important'* (Interviewee II, 1 September 2006).

'Need mentors – like our mother, speaking from experience or an aunt or uncle talking to them. Most of the people that get into The Connection do not like Winnunga because Winnunga would not make an attempt to help any

of them at first. Winnunga turned them away. These were workers who have now left Winnunga – some are still there. Some of these young ones have even overdosed because Winnunga couldn't help them. Gave them nothing – turned them away. They come in and they pleaded with Winnunga – 'Help I want to get off, I want to get my children'. One girl died and left 2 children behind and her mother had to bring them up. Our mum had to be her counselor and still counsels that family' (Interviewees GG and MM, 11 September 2006).

'Drug and alcohol follow up; outreach services to the community [are needed]' (Interviewee CC, 8 September 2006).

'Well, I'm hoping that when the Aboriginal Justice Centre gets up and running, this is something that we need to work on through them. Because primarily this is going to be their role in getting all these structures up and running with regards to criminal justice. So hopefully they will have some strategies that they can use when people are in prison. One of the recommendations of the Royal Commission into Aboriginal Deaths in Custody is to try to keep people out of the system, and I think that's something that the AJC needs to work on really hard, because it's not happening' (Interviewee AA, 25 August 2006).

Interviewee AA's experience of her family's transgenerational trauma emphasizes the important role of Aboriginal Health Services in delivering holistic care to the community:

'Sometimes Aboriginal organizations have a bit of an attitude about people with drug problems. Not everybody, but I think on the whole drug addicts are not It is probably a deep seated thing that happened, and my boys probably took to it [drugs] because that is the way my husband and I were. I mean he is an alcoholic and I pushed and pushed too hard with them. I hit them when they needed to be hit. Basically, I did everything for my kids, and because I was the one who did it I probably came out not looking too good because I was disciplining them. I was doing all that myself because I could not rely on my husband but that's probably why my kids thought that I was too strict with them, and they probably thought their father did not care and all. These little things play a part in young people's life when they grow up. I was emotionally battered when my mother died and I was only 10 years old. My sister can't even remember her. Things happen when you are a child that does reflect on your behavior, but it is up to that individual as to how they want to react to what happens. But these are the things that can be discussed with counselors; this is how you are going to find out why are they are still in that



cycle. We need to work on a way of getting them out of that cycle and that is not happening. Other people do' (Interviewee AA, 25 August 2006).



Chapter Twelve – SUPPORT ORGANIZATIONS’ PERSPECTIVES OF ABORIGINAL PRISON HEALTH

The main factors contributing to incarceration are drugs and alcohol. Underlying this is past history, stolen generations, dispossession, discrimination, petty offences, mental health, lack of education and employment, police harassment, poor diversional avenues, breaking parole, trauma and anger, family problems, bad health, poor diet, money issues and issues about self identification. Stopping the cycle of incarceration commences in pregnancy, and with responsible parenting in growing up strong, resilient children. Increased restorative justice opportunities are essential. Aboriginal people take poor health into prison and start from a much lower base than other prisoners. Inmates at the BRC are taken off drugs on admittance and those that feel they need long term opiates are offered methadone. On admittance they are seen by a nurse and a doctor and given a health assessment and a mental health assessment. Not all prisons offer a methadone program. There is overwhelming concern about contracting hepatitis C in prison and bringing it into the community on release in the absence of a prison needle and syringe program. Good dental treatment is very important in prison and not always accessible. Prisoners have a preference for an Aboriginal Medical Service as it provides support and strong connections with the community. Aboriginal prisoners do not cope well. There is a need for well trained Winnunga Mental Health Workers.

People on remand cannot concentrate on educational courses because of their immediate concern with court appearances. Training for employment is important. Need exit programs for throughcare. Winnunga and Elders (for mentoring) and support organizations can provide this pre- and post-release. Consequently, partnerships between Winnunga Health Workers and Aboriginal Liaison Officers are crucial. Structured services to prisoners and families on release should be provided by a network of support organizations detailed in Chapter Thirteen (including Winnunga). There is a need for a drug rehabilitation Bush Farm in the ACT. Spiritual needs could also be met through the Marumali Healing Program and Ngangkari Spiritual Healing. A Winnunga Prison Health Service Team is necessary to support the prisoners and their families. The Team members’ welfare should be monitored. A sense of influence and control, and support in the work place is essential for their wellbeing. They should be rotated, rested, debriefed and counseled regularly.

12.1 Introduction

This chapter examines the data gained from interviewing representatives of 39 support organizations in the ACT, Queanbeyan NSW, SA and Victoria (see Appendix A). This includes the medical and social and emotional support provided to prisoners and their families by Winnunga and other organizations. For example, government organizations such as ACT Health and ACT Corrective Services provide medical and correctional support to the Remand Centres' inmates, and on release, through correctional Parole Officers. Other organizations such as Circle Sentencing, Prisoners' Aid, the Aboriginal Justice Centre and the Australian Federal Police are associated with criminal justice matters. Mental health and drug and alcohol support are auspiced by ACT Mental Health, the Australian Hepatitis Council and Directions ACT. These support organizations' perspectives provide a greater appreciation of the importance of addressing holistic health issues for prisoners, ex-prisoners and their families. Methods of ensuring the ongoing welfare of the Winnunga prison health workers are also examined.

12.2 Aboriginal Incarceration

When support organizations were asked to comment on how most Aboriginal people get to be in prison they all considered that drugs and alcohol were the main factors of incarceration. One respondent, an Aboriginal Health Worker at the Port Philip Prison in Melbourne, commented that he was extremely surprised that one of the Aboriginal prisoners he visits is the first Aboriginal non-alcoholic and non-drug addict prisoner he has encountered (Port Philip Prison Health Worker Interviewee 01, 19 October 2006). There was also a view that drugs are the biggest problem nowadays, and seem to be getting worse, whereas in the 1970s and 1980s most Aboriginal people were in prison because of alcohol-related crime (Worker at The Connection and Winnunga Health Worker, Interviewees 02 and 03, 14 September, 18 October 2006).

The other reasons given were past history, stolen generations, dispossession, discrimination, petty offences, mental health, lack of education and employment, Police harassment of young males, poor diversional avenues, breaking parole, trauma and anger, family problems, bad health, poor diet, money issues, and issues about self-identification. Regarding these issues, the Winnunga Psychiatrist considers that:

'Drug and alcohol abuse/dependence are often seen to be the main problems, often chaotic leading to incarceration. However, their use is often to regulate people's often chaotic emotional world. Their instability is secondary to the numerous factors and issues, in particular community disintegration and parenting difficulties which are secondary to stolen generations issues' (Interviewee 23, 21 November 2006).

The following accounts elaborate on these issues and demonstrate how Aboriginal social determinants of health combine with drugs and alcohol to contribute to a prison sentence. The perspectives of an Aboriginal employee of the ACT Corrective Services, Indigenous Services Section follow. His views also take in his experience as a former prison officer:

'If you read the Royal Commission into Aboriginal Deaths in Custody and the report's recommendations it pretty well sums up the plight of Indigenous people, but it also provides a range of actions and options that may assist in overcoming some of the disadvantage. In regard to employment opportunities, if you look at the Aboriginal community the condition that people are asked to live in, rival third world conditions. From some of the statistics in health, housing, education, and lack of opportunity, we can see the disadvantage and social plight of Indigenous people.'

'In this city we are a fairly well off community, but there are Indigenous people living on the fringe. Aboriginal people are one of those seriously disadvantaged groups. When you don't have a land base, there are positives and opportunities that are absent without that land base. When you don't have opportunities – it is about survival, and if there are limited opportunities for our kids where are they going to go, what are they going to do? They may well get into activities, deemed as unacceptable by society, which becomes the norm and consequently a way of life and a way of survival. We see a lot of our kids out in the streets and not at school, and it may simply be because they don't have the bus money or are required to stay at home to help the family where there might be 7 or 8 or more that need support. I think this community is a little better off than other communities, but there is still a lack of real opportunity for Indigenous people and consequently life becomes a real struggle.'

'To answer your question about how they get to be in prison, I don't know what the answer is. But, I do think that while we aren't necessarily engineered in any certain way, we are the result of our environment. When people are

discriminated against, that becomes a tough road to ask anybody to go down, and I challenge anybody to get by in those circumstances. A lot of our people don't get by because they have little or no support, and they have to fight for any scraps they can get. To get help Aboriginal people rely heavily on community organizations such as Gugan Gulwan Aboriginal Youth Corporation, and Billabong Aboriginal Housing. I would hate to think where our people would be without them, and where they would end up because without these organizations they would have nowhere to go and they would not survive.'

'While education continues to offer increasing positive outcomes, resulting in more qualified kids coming through the system, there remains considerable numbers who fall off the band wagon and miss out on an education because other factors come into play such as limited housing opportunities, or family/survival priorities. As a result these kids in later years will lack necessary skills to compete for a job let alone hold a job. You also need money to buy food or jump on that school bus or to pay the rent and have a roof over your head. If Indigenous people don't have the basics then what do they do?'

'With drugs you need to be careful. If drugs take hold it is very hard to break the habit. Oddly enough drugs offer people opportunities to socialise, and to develop survival and negotiation skills within their community. Although, there is a price to pay and we can see this through the high rates of imprisonment and recidivism in the prison system. It is not until the mid to late 30s that you start to see some change. This is where the community comes into play because the Aboriginal community actually support their own people as best they can even though they have problems of domestic violence, sex offences, drug and alcohol and other related matters.'

'They are in custody for a short time, some 21 days with some exceptions extending to up to 2 years. Sentences usually range from 6 to 36 months and they are released back into to community in a clean state. Prisoners generally have the attitude that they want to go straight and stay out of prison, but often find themselves back in the system. They have good intentions but don't have the necessary support to help them in the community, and they need to develop skills but that doesn't happen overnight.' (ACT Corrective Services, Indigenous Representative Interviewee 04, 12 September 2006).

The following accounts by a Nannies' Group in the ACT community, who

are concerned about their children's repeated incarceration, and a Winnunga Health Worker provide some insight into young people's negative experiences of the school environment which can lead to encounters with the criminal justice system.

'[They are incarcerated because of] drugs and alcohol and before the drugs and alcohol the circumstances, and lack of education. If they show any intelligence at school God help them. In a lot of schools they are not encouraged. They are labeled trouble makers. The young Aboriginal child has the dramas or the fights at school – their race is slurred upon and they retaliate with hitting them with a rubbish bin. So the pressures are to head for the drugs and alcohol and if they can't find a job With lack of education, things happen and it is a snowballing effect and they get on drugs and other things associated with drug use, and the next step is prison. Sometimes they go to a juvenile detention but at 18 they step out to remand and go straight off to Goulburn Prison. It is because of lack of education and the way things are at schools; they don't get the education they need and they take a backward step instead of trying to go forward' (Nannies' Group Interviewee 05, 13 September 2006).

'Flicking them out of school when they play up sets them up for trouble and bad habits. There is constant harassment of young people especially young males. Once they are known they are up for the slightest thing. The young ones lose all respect for the Police and think they will not get a fair deal, and if you have no money in your pocket – it is stupid stuff, that is, using substances' (Winnunga Health Worker Interviewee 06, 14 November 2006).

A drug and alcohol researcher at the Australian National University also comments on the lack of opportunities for Aboriginal people which lead to incarceration:

'They are committing more offences than non-Aboriginal people and there is discriminatory processing at every point in the system but primarily at the front end [the Police], and the high level of offending is because of high level of poverty and separation and all the other issues. And the diversionary services are deficient for the needs of Aboriginal people. Either that or they don't meet the needs very well – only small numbers go through Circle Sentencing which is pretty well irrelevant in terms of numbers and most people are not eligible (this is only for minor offences). In Canberra we have a restorative justice program but people who need it most are not eligible. We have a diversionary program for drug offences and most people are not eligible. And we are not

going to get anywhere until the mainstream services serve the Australian population properly in all different facets. This is frustrating because it would not be difficult to change this. The evidence is clear that restorative justice is extremely valuable for a very significant proportion of non-Aboriginal and Aboriginal offenders and the argument is often put that it is more significant for Aboriginal offenders but that is misrepresentation. But I think there is a special argument for restorative justice for Aboriginal people because of the high level of consciousness within Aboriginal communities of community, and of the strength of community. And you have something you can build on fairly readily, whereas these value systems may not be there in the non-Aboriginal community' (ANU Drug and Alcohol Researcher Interviewee 07, 23 October 2006).

When considering the reasons for imprisonment and the lack of diversional activities, an Aboriginal Policy Officer at the Australian Hepatitis Council is of the opinion that:

'It's common knowledge within Aboriginal communities that a lot of the things we're imprisoned for are what's known as the trifecta in Aboriginal communities, which is assault Police, resist arrest, and offensive language. And they're so easy to charge Aboriginal people with. Repeat offenders - they end up in prison, because they might be unemployed, long-term unemployed. Yeah, and then you put mental health issues on top of that, and drug and alcohol issues, and the majority of our people should never be within the prison system, they should be in diversional activities, whether it be drug and alcohol programs or be it a mental rehabilitation setting' (Policy Officer, Australian Hepatitis Council Interviewee 08, 10 October 2006).

A Nurse at the Belconnen Remand Centre (BRC) comments on the drug and alcohol connection with imprisonment:

'Actually, I've just done the monthly stats for September 2006, and I think we had four Aboriginal people come in last month, and they were all alcohol or drug related. It's mainly drugs, but it's the older Aboriginal person that would have any alcohol problem. With our young Aboriginal men, particularly, it's usually IV drug users. Well, it starts with petty theft and then quite often that can go wrong and that's where quite often it can lead to violence. They want to get in and out and get what they need, but things happen beyond their control sometimes. And the other problem now is ice. It's really starting to get a huge big problem. People that I've known for a few years that weren't ice users are now using it because it's cheaper and it's out there. You know,

there's just so much of it. So your heroin users are using ice now instead of heroin. It's leading to a more violent type of behaviour. That's the problem with ice. And then there's the associated mental health issues with it as well' (BRC Nurse Interviewee 09, 11 October 2006).

The following account provides one perspective on how to address drug use in the community:

'Oh, drugs. I can give you the stats on it. Eighty per cent of all NSW people that are incarcerated are [there for] drug related crimes. I think it's 15 per cent are mental health, so that leaves only 5 per cent who are there for actual criminal activity. The average sentence is six months, six to eight months average. So that's very short. Recidivism is very high in Aboriginal communities. And if you look at juvenile Aboriginal recidivism, it is up to 90 per cent. And that will carry on into the adult system, so we really need to look at juveniles. But, I mean, recidivism is caused out of their drug use. And we're not addressing drug use. And unless we can address that adequately Methadone program is one way of addressing it long term, juvenile crime is another' (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October 2006).

Other respondents commented that breaking parole was a common occurrence and a reason for imprisonment. The Marumali Healing Program is delivered to Aboriginal prisoners. This program has found that their incarceration is most related to the consequences of trauma and anger, and drugs and alcohol. They also break parole conditions and need practical support in this area. A Victorian prisoners' program communicates between prisoners and their families about their welfare. It also supports people on parole with meeting their commitments (Program Manager, Marumali Healing Program Interviewee 11, 15 October 2006). Ngangkari Spiritual Healing is another program which also assists with spiritual healing, mental health and emotional wellbeing (ABC 2003).

The majority of the case load of one ACT Corrective Services' Parole Officer is dealing with breaches and their consequent return to prison (Interviewee 12, 4 October 2006). A Winnunga Health Worker also provides views on parole commitments:

Crime! Drug and alcohol and boredom. And no work. They're not violent crimes, though. All the research says that in reality they're getting locked up for very minor stuff. And they tend to get locked up for the numerous

breaches. And so there's a huge list on the fridge to do with parole, and often those things aren't manageable for a person without support – an Aboriginal person without support. And I certainly deal a lot with their Probation/Parole Officers, because I tend to think they cross the line a little bit and I say to my clients, 'You don't have to tell them everything'. They want to know a lot about their private life. They often will push a detox and a rehab option when the client's nowhere near that thinking. So I say, 'Look, they're on methadone, they're stable. That's not an issue at the moment'. And it's been a clinical decision made by their Doctor and their Nurse. So, hopefully, over time we've sort of chipped away at that mentality. You know, the prisoners say, 'Oh, I've got to go and see a Probation/Parole Officer'. 'Okay, some of your stuff is private. Your health is private. It's not open for everyone'. But because they've been in the system and they feel very vulnerable, they think they've got to tell everybody everything. But just letting them know they own some of this stuff – not to share it, you know?' (Winnunga Health Worker Interviewee 13, 11 September 2006).

12.3 Prison Health Care

The following accounts provide some insights into Aboriginal inmates' life prior to incarceration, their health care on entry, and their attitudes to health care while in prison. The Aboriginal Liaison Officer (ALO) at the BRC has observed that because they are not busy looking for drugs in prison they attend to their health. They also develop a need to attend to the welfare of their children while they are free from their involvement with drugs on the outside (BRC ALO Interviewee 15, 18 September 2006). The BRC Doctor considers that Aboriginal people take poor health into prison and start from a much lower base than other prisoners:

'Before they come into custody often their lives are in chaos and their immediate need if satisfied is often counter productive to the rest of their wellbeing and their health suffers as a result. A lot of people get in there as a result of what I call making bad decisions, that is, they need something right now and they get it regardless of the consequences. And the consequences might be that somebody is injured or somebody might contract an illness of some sort; somebody loses something – some stealing or a crime is committed in order to fill their immediate need, and then the consequences catch up with them. But then they come into custody and all that chaotic lifestyle is controlled by the highly controlled hierarchical environment that they are in. That gives people an opportunity then, sometimes after a period of acute

distress from the fact they are in custody, and that they are withdrawing from a pattern of life they have been accustomed to, and are withdrawing from the drugs – so that is a lot of difficulty to overcome. Then there is some order in their life and they have little choice but to start thinking about what they are going to do. And often their orientation is, ‘How am I going to get out of here?’ And their legal processing is of major concern to them. So their health needs may not be a priority. But it is one of the things they have an opportunity to think about. And we provide them with availability for them to look at and monitor whether they have hep C for instance, or HIV or hep B, whether their immunizations are up to date, and any other minor ongoing health problems that can be addressed’ (BRC Doctor Interviewee 16, 13 September 2006).

On admittance to the BRC they are initially seen by a Nurse, and then a Doctor at the next opportunity (may not be available weekends) and given a health assessment and a mental health assessment. Injuries or health matters can also be addressed (BRC ALO Interviewee 15, 18 September 2006). The BRC Doctor describes the BRC protocol on drugs on admittance:

‘Everyone is detoxed within the first one or two weeks of their being there. Everyone is detoxed off the drugs that they may be dependent and heavily using when they come in. So it is an involuntary detox. They are not helped off, they are taken off – depending on what they have been using. If they have been taking valium it is a valium reduction. If it is heroin it is diloxine and valium, if it is alcohol then it is short term valium, and if it is speed, amphetamine related drugs, they don’t need any medication. They are not withdrawn from cigarettes – they still smoke in there. The drugs are brought into the place, so some of them have access at various times to drugs. I think it is probably a lot less than what is in the community. So they are detoxed basically and then those that feel they need long term opiates are offered methadone’ (BRC Doctor Interviewee 16, 13 September 2006).

The health protocol for admittance to prisons including Goulburn and Cooma, which are medically serviced by Winnunga, is the same as the BRC (described above). However not all prisons offer a methadone program (Winnunga Doctor Interviewee 22, 17 November 2006). According to the BRC Nurse the health services administered to Aboriginal inmates cover a wide scale:

‘It’s all the general health type of stuff – their medication, screening, immunisation, detoxing from whatever drugs they’re on, if they need any first aid, whatever. I think they’re better in some ways than some of our non-Aboriginal drugs users, especially with their personal hygiene, and with their

teeth – they are quite keen. We get less teeth problems with Aboriginal people, who are drugs users than we do with non-Aboriginal people. I don't know about the incidence of hepatitis C, and whether they share needles and all that sort of stuff any more or any less than non-Aboriginal Australians. They certainly use the clinic and have no hesitation in accessing the GPs if they need them. They prefer to see the Doctor from Winnunga, but if it's an urgent thing, if I say, 'Well, you need to see the Doctor tomorrow', or today or whatever, they don't usually baulk at that. They're quite happy to see anybody. If it's nothing urgent, then they're quite happy to wait until the Tuesday, when the Doctor comes in. That is what happens inside. What they're doing out on the street I can't say. But they certainly come in in a more healthy state than some non-Aboriginal people. Whether it's because they do have that community outside that looks after each other, I don't know. I'd only be generalising there' (BRC Nurse Interviewee 09, 11 October 2006).

Other representatives from support organizations considered that attending to dental problems was of the utmost importance in prison:
'They tend to extract teeth in prison and this is not good for people's self esteem – especially for a woman' (SA Corrections Executive Officer Interviewee 19, 17 November 2006).

'From my talking to the boys in, especially Bathurst, in New South Wales prisons trying to get to a Dentist is exactly the same as in the community, it's almost impossible. And the wait can be five years in the community. They say it's not, but it can be. So if Winnunga has a Dentist then I'd be saying, 'Send it in to the boys', because oral health care is a big thing, you know? Poor hygiene, poor nutrition, illicit drugs – licit drugs. Methadone is the worst drug on teeth, yet we prescribe that. In fact, if you are on a methadone program you're supposed to have priority over other people to get dental treatment. So yes, if Winnunga has access, I'd be sending a Dentist in' (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October 2006).

The Aboriginal Policy Officer from the Australian Hepatitis Council provides a further perspective on how prisoners look after their health:
'Yeah, given Aboriginal people generally don't access health care services, especially if they're not culturally appropriate ... But in saying that, sometimes prison can be a place where people will go and become healthier than what they are outside of prison. There's less access to certain drugs and alcohol, but then they have access to gym equipment and that free of charge, and the likes'.

'Yeah. And then you put in a type of prison classification and the likes, where a certain prisoner might be at a certain prison which mightn't have a hospital per se, and he doesn't want to leave his prison so he may go unwell for quite a while, because he doesn't want to get shanghaied to a prison that has a hospital but has a worse reputation, such as Long Bay in Sydney, or the MRRC in Sydney as well. And so if you're based within a low-classified prison and it's pretty ... you find it easy-going there, I don't think prisoners are going to want to put their hand up to be shanghaied to another prison and then get caught up in the system again, and then it'd take them months to get back to where they'd settled and the likes'.

'I sort of had a good understanding of that last year when I was on the Justice Health Community Justice Support Group and we got to meet with some prisoners and these were some of the things that they brought up. They're not going to say that they've got a broken arm or a broken leg if they're going to be sent from, it was John Morony Corrections Centre in Windsor, in Sydney, if they were going to have to be sent to Long Bay. There was a safety issue. That prison at the time, there'd never been a stabbing within the prison, there still hasn't. There hasn't been a death within the prison. So from a prisoner's point of view it's a good prison to be in and they wouldn't give that up too lightly. It's something you've got to think about as a prisoner' (Project Officer, Australian Hepatitis Council Interviewee 08, 10 October 2006).

When representatives of support organizations were asked about prisoners' attitudes to consulting Aboriginal or non-Aboriginal organizations the BRC Aboriginal Liaison Officer and the BRC Doctor who shares the work at the BRC with the Winnunga Doctor commented as follows:

'While on remand everyone has the option to see whichever Doctor they wish to see. So they put in a request which goes through the Custodial staff or they ask the Nurse if they can see the Doctor. I don't know that people deliberately select the Doctor. For the most part they see whoever is next available but they have the option of asking when someone is due to come and to see them. The Aboriginal people don't tend to select the Winnunga Doctor just because ... to put it another way – they seem to be happy to see whoever is available. I think all the Doctors working there have a very similar attitude that people are there to get the best health care we can provide and it is a complement to them that people don't single out Doctors. Then you have the occasional individual that has a personality clash or difference of opinion, or does not like what one Doctor says about something. They will tend to go and see all

of the Doctors to try and get what they want which I guess I would do as well. If you want something and you know what it is you keep trying to get it. The Winnunga Doctor does a regular Tuesday clinic. It is pretty regular, and he has done that for 7 years' (BRC Doctor Interviewee 16, 13 September 2006).

The BRC Aboriginal Liaison Officer also considered that the remandees did not mind whether they saw a Doctor from Winnunga or a Doctor from a non-Aboriginal organization (BRC ALO Interviewee 15, 18 September 2006).

While many respondents considered that all Aboriginal prisoners prefer Aboriginal Medical Services (including dental services), other respondents considered that the preference for Aboriginal or generic services was evenly distributed. The Aboriginal Prisons Project Officer, NSW Health Services adds:

'But when you talk about health promotion and other things like that, definitely Aboriginal. Yeah. The education programs, definitely, they want to see an Aboriginal. And New South Wales did sexual health, South Australia did drug and alcohol, with Koori images. And they loved that. So if you have a Koori face or an Aboriginal face in your literature, it goes over better as well, you know?' (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October 2006).

A Winnunga Health Worker explains that the preference for Aboriginal Medical Services in prison is because of the strong connection and support which is provided from the Winnunga Doctor and Aboriginal Health Workers.

'Yes, [they are in favour of Aboriginal organizations] usually because they know family at Winnunga. And if family works there then it's going to be okay. Aboriginal Health Workers are really important for that connection, and the visits that are maintained. Because when I've gone along with them as a dual visit – in my time I never went on my own, it was always with an Aboriginal Health Worker – they could support: 'Oh, so what's happening with auntie?' and, 'Oh, I spoke to uncle', so that scene. Yep, particularly for the Cooma and Goulburn Prison visits the Health Workers are important. I don't go to those ones; this is just the local one [the BRC]. But I have been part of, say if someone's coming out of Junee Prison and they want to start methadone or buprenorphine, I organise that here at Winnunga. So they might be ending up going to New South Wales but we still initiate the paperwork, because you have to apply for prescriber rights and the prescription and finding the

chemist. There's a lot of this background. So they say, 'Look, Doc, when I come out, I want to get on the methadone or the buprenorphine'. So the Winnunga Doctor comes back and says to me, 'We need to get this done'. So I find a chemist and get their address and details, so that when they do walk out they can just go straight to a chemist' (Winnunga Health Worker Interviewee 13, 11 September 2006).

12.4 Drug Use in Prison

The Aboriginal Policy Officer from the Australian Hepatitis Council considers that a person's physical presence can be a reflection of how mentally well they are in prison and whether they have taken up using drugs in prison:

'And there's good evidence to show the first time they inject is within the prison system. So that sort of goes to show their mental state, you know, their mental wellbeing at that time, that they're that depressed, they feel no way out or no way forward, no future, that people turn to drugs. And that has other implications of dirty needles, learning bad injecting culture, and then taking that back to the community, that it is normal to share syringes and the like – so just some of the flow-on implications that that has as well. It's quite sad' (Aboriginal Policy Officer, Australian Hepatitis Council Interviewee 08, 10 October 2006).

The issue of obtaining drugs in prison has led to a Drug and Alcohol Worker's concern about contracting hepatitis C in prison. The respondent, who advocates introducing a prison needle and syringe program, relates a young man's account of drugs in prison:

'He said he had a syringe in there and wasn't using it and some fellows had cannabis and said they would give him the bag of cannabis if he would give them the syringe. Two days later he heard that ten of them were using the syringe' (Drug and Alcohol Worker, Gungan Gulwan Aboriginal Youth Corporation Interviewee 20, 18 October 2006).

An Aboriginal Support Counselor, Directions ACT also provides a perspective of inmates' use of drugs in prison:

'A lot work out and go off the drugs and have a structured life in prison. But they share the same needles in prison over and over and over again. One prick already blunts a needle. If they don't look after themselves they can get worse and worse. The retractable needles have not worked as there is a way of reusing the needles so this has been put on the back burner. Needles in prison

are a danger to workers and visitors and prisoners. In prison they could have an injecting room correctly supervised like Kings Cross and make drugs a little more legal they could like ... picking the methadone up, maybe getting a small amount of heroin to keep them going. But I can't see that happening in my life time. And you will probably find that some prisoners don't want to go there. So they should look at it more as a medical issue, addiction is a medical issue. There are people in the BRC who should be in hospital. The prisoners are treated pretty badly sometimes when people are locked up. There are not enough cross cultural sessions for the Police. In Sydney they have drug courts which work really well. Some of the Judges in the ACT are lenient but a lot are back using again' (Aboriginal Support Counselor, Directions ACT, Interviewee 21, 20 October 2006).

On 18 November 2005, an Australian Hepatitis Council Media Release advised that the ACT Health Minister had confirmed that a trial needle and syringe program would be considered for the new ACT Prison (AHC 2005). It added that this would be a first for Australia. In January 2007 the Queensland State Coroner also showed concern about the inability of the Queensland Department of Corrective Services to keep drugs out of prisons and recommended that prisoners be given access to clean syringes. He considered that this initiative would recognise the obligation to minimize the spread of blood-borne viruses within the prison population and the community on release (Desmond, *News.com.au* 19 January 2007).

The following section provides various perspectives of drug use in prison and the efficacy of introducing hepatitis C testing and counseling, and prison needle and syringe programs:

'Some haven't been to a Doctor and don't go in prison. Well, I guess the Winnunga Doctor has that opportunity to visit the prison and then say, 'Look, when you're out of here come and see me and we'll do this, this and this'. But he can actually treat stuff while they're in prison, and that shouldn't change [in the new ACT Prison] you know, for some of ours we'll probably get long-term sentencing when the prison comes here. If they fit the criteria for hep C treatment, then I would like to see them start to have treatment while they're in prison. I think at the best they do a blood test to see if they're hep C positive, but nothing else much is done around it. And the most important thing about hep C testing is the pre-counseling. Now, the Winnunga Doctor and I did the S100 prescriber training a couple of years ago for GPs to initiate treatment for hep C, but it just hasn't come. There is a protocol. There's a certain

group, and there's subgroups of people with hep C that are not eligible for treatment, but there's those who are. So you genotype those. And a lot of talk about 'treatment' is pre-counseling – because there are side effects of every treatment, as you know' (Winnunga Worker Interviewee 13, 11 September 2006).

'Unless they have a reason to go through the Nurse that seems to them as being legitimate, they won't go. And usually it's a female Nurse, and considering most inmates are male, that's usually not culturally acceptable. I've found it's a little bit different in the younger generations, they don't mind. In fact, I visited some boys in St Mary's and they were saying they wouldn't go to a male because they would be seen as gay. They'd rather go to a female. So that's a little weird quirk for culture, but generally adult males will not go and see a female Nurse about what they see as men's business. So anything to do with reproduction, the genitalia, anything like that, they just won't do it. And if they have been injecting outside, or even are injecting inside, they won't go to see the Nurse about any of those problems because it's still illegal. I mean, I know it's against ... and I would be howled down by saying it publicly, by trying to introduce it, but we funnel them in and make it compulsory. We should be working on the guys and girls that have come in contact, to make sure that they go – even if we go and hold their hand and say, 'Okay, let's do a full screening and get you better now, so that you have the best possible start when you re-enter the community'. You know, what's the point of having them sick, when we've had them in prison for three months, even six weeks' (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October 2006).

A Doctor at Nunkuwarrin Yunti Aboriginal Medical Service in Adelaide commented, as a prison Doctor, that programs for testing for hepatitis C on arrival have been in place, with the inmate's agreement. However these programs are very often discontinued over time. The Doctor favours the introduction of a prison needle and syringe program (Nunkuwarrin Yunti Aboriginal Medical Service Doctor, Interviewee 22, 18 November 2006).

On the matter of sexual health in prison, the Aboriginal Prisons Project officer, NSW Health Services considers that:

'Pure education works for sexual health. Having a Nurse there doesn't work; the boys still don't go to them. Sexual health clinics are very, very badly accessed. What else? Pure education, having an Aboriginal educator, so a

health educator in there delivering programs works. So having somebody there full time would be ideal. Yeah. And it may even work to actually encourage them to go to the clinic just for checkups, you know?’ (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October 2006).

All the support organization respondents observed that the state of prisoners’ health was much better on release. A Winnunga Aboriginal Prison Health Worker and the Nurse at the BRC sum it up:

‘Yes, they do exercise, and eat well. It can be a short time but even within a couple of weeks we see their health improve. You need to give them a good couple of weeks to withdraw, so once they withdraw and they’re eating you can see big improvements in just a couple of weeks. And when they come back from New South Wales [prisons] the court might have a look at them and think, ‘Oh, my God, you look so beautiful’. You know, they’ve put on weight. Of course, some of them have been using, but most of them come back and look great’ (BRC Nurse, Interviewee 09, 11 October 2006).

‘They come in skinny through drugs, unhealthy – you speak to some of the boys and say ‘Last time I saw you you were solid as a rock – you have started using again?’ Then you get them inside they just eat, eat and eat. Some guys actually stack on the kilos which is a problem and they are not exercising. Then the young guys mid 30s train and maximize protein intake so they can put weight on and they train once a day. So both in weight and in cardio, they come out with a great body and then some go back to their old habits. They are well educated on how to change. Giving them the opportunity on the outside to maintain that is a problem – that can be an expensive exercise’ (Aboriginal Health Worker Interviewee 01, 19 October 2006).

On the issue of drug detoxification and drug rehabilitation, the Winnunga Psychiatrist (Interviewee 23, 21 November 2006) recommends that:

‘Although drug detoxification is important its value is only minor compared to the benefit of drug rehabilitation. Drug ‘rehab’ is to learn how to live life without drugs, but great benefit could be gained also for prisoners in ‘how to live life’, and dealing with being able to manage ‘ordinary living’ on release from gaol’.

12.5 Mental Health and Coping with Incarceration

A Winnunga Health Worker who visits Goulburn and Cooma Prisons with the Winnunga Doctor describes the stress which can be experienced by prisoners:

'Their outside appearance can be calm but some of them are stressed. I knew a person 12 years ago who had been in prison and he did not have a shower while in prison because he was scared of being raped in the showers' (Winnunga Health Worker Interviewee 03, 18 October 2006).

The representatives of organizations which support Aboriginal prisoners provided a variety of views about the way Aboriginal prisoners cope in prison. The Aboriginal Prisons Project Officer, NSW Health Services provides a perspective:

'Well, you've only got to read the reviews for Deaths in Custody. They don't cope well at all. And there's a number of reasons why, apart from liberty being taken away. In New South Wales, particularly, they get moved round very, very regularly, so they can't keep family ties. They don't access treatment very well. In a lot of cases they're in confinement – I mean, Aboriginal people are communal people still. Even though the 'tribe' as people know it is no longer there, we are still very tribal, and kinship and lineage mean a lot. So if you take away their support mechanisms, which is his family They may develop some friendships inside and they may have cousins inside or whatever, but you take that away by putting them in solitary or separating them from that, they've got no support mechanisms, you know? So depression sets in. So they don't handle that very well at all, and that could be very easily managed if you stopped moving them around. You know, just things that are simple – simple Yeah. And look, the Deaths in Custody said all that, yet it's not being followed. The only recommendation that I know that they really hung onto and did was to take all the hanging points out of every cell. That was the only one they accepted. The [issue of] emotional instability they really haven't grabbed hold of' (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October 2006).

The Manager, Indigenous Services, ACT Corrective Services, comments from experience:

'As an officer I have seen a different side and it is true that people don't cope all that well and prefer to be outside rather than inside. They accept they are locked up because they have committed an offence. They are resigned to

the fact of doing their time. they know they are going to be looked after – 3 meals a day a bed and a hot shower. They can have their visits, exercise in the yard, make phone calls, get tobacco, play hand ball, do education classes and watch a video. This may not happen on the outside. They may not have anywhere specific to go, while others have families and a home to return to. Prison is time out. It is a safe and secure environment and they don't have to be looking over their shoulder. But they do have concerns while in custody – wondering whether their family is being looked after. There might be other issues that they can't help and that becomes very frustrating and potentially volatile. As a result a situation can blow up very quickly. We try and get them to talk to us to calm down, and to try and resolve the issue. But, for some it can be difficult and we find that anger and hostility is often the way they deal with issues. We need to be aware of the different types and how they deal with matters on the inside. The new prison will be user friendly, and a safe and secure environment based on an open campus style.' (Manager, Indigenous Services, ACT Corrective Services Interviewee 04, 12 September 2006).

The Doctor at the BRC considers that:

'These characteristics don't necessarily apply to any one person but I think there is a tendency that Aboriginal people are much more distressed when separated from their community support. That might be their immediate relatives or it might be people who they consider relatives, that is related by association. If someone in the Aboriginal community is called an aunt or an uncle that does not mean they are a blood relative but the relationship is as if they were. When they are separated from those support mechanisms there seems to be a greater record of distress and I am sure it has been identified in the investigations into Aboriginal deaths in custody. It is one of the major things that need to be considered. There are Aboriginal workers from Winnunga as well as the Aboriginal Liaison Officer there to support them but I think they are stretched to the limit sometimes as well' (BRC Doctor Interviewee 16, 13 September 2006).

The BRC Aboriginal Liaison Officer (ALO) thinks that it depends on whether they have been in prison before as to how stressed they become. They can be stressed first of all and then feel quite at home. The ALO ensures their safety, and helps them in the family liaison role (BRC ALO Interviewee 15, 18 September 2006).

The Nannies' Group presents family perspectives on coping in prison:

'They don't cope. They try to keep the image and you can't be babbling and crying as mummies' boys do, so they try to keep an image and can't relieve that which is being kept in. Then they come home with all that anger and stuff still inside. Services to help stress in prison would help – Winnunga should step in and provide that service in prison and when they come out. Need well trained mental health workers not someone who does not know their job and can't deal with the situation – they are not going to help them. Don't know [how they cope with family crises] – can only speak on a recent crises and how it was left to the prisoners to help each other. The prison should be more accountable for things when crises do happen in families. I am talking about deaths. There should not be so much red tape. They were well aware of the situation but no one did any paper work. It is very damaging for the family because the boys wanted to be with the family and they could not' (Nannies' Group Representative Interviewee 05, 13 September 2006).

A Nannies' Group representative further stated that if a cousin had not been in prison she does not know how her son would have coped in prison when he received the news that his brother had hanged himself. This caused her worry as a mother as no one rang the family to advise how he was coping in prison. The best thing the prison social worker could have done would have been to let her incarcerated son phone her. She insisted on telling her son and his cousin about the death herself by phone rather than have someone from Corrective Services tell them (Nannies Group Representative Interviewee 05, 13 September 2006). Other respondents observed that Aboriginal prisoners support each other and they also receive support from Winnunga during their visits (representatives from Marumali Healing Program, Directions ACT, and Winnunga Health Worker, Interviewees 11, 21, 29, on 15, 20 October, 9 November 2006).

The importance of family support is further emphasized by a Winnunga Health Worker:

'Nobody would cope, would they? Yeah. I think the thing they miss is the family contact. Well, I know it is. And then ... I know BRC can decide there's no contact visits, or the family's made all this effort to get a bus out there or some assistance, and then they say, 'Oh, you're too late'. Many of our inmates have got young families' (Winnunga Health Worker Interviewee 13, 11 September 2006).

However, the Aboriginal Policy Officer, Hepatitis Council, considers that the attitude within the Aboriginal community about the security of kinship in prison is not a healthy one:

'There's that break of the family connection. But then in saying that, Aboriginal prisoners feel - what would you say - especially young kids going into prison, that they'll be right because they are Aboriginal and there's that kinship within prisons between Aboriginal groups there. And I think that's a real shame, and something that really needs to be broken within Aboriginal communities and Aboriginal youth. It's not the turn-off it should be. And that's common knowledge within young Aboriginal kids. But I don't know how we can work to address that' (Aboriginal Policy Officer, Australian Hepatitis Council Interviewee 08, 10 October 2006).

The Winnunga Psychiatrist views the role of the Winnunga Mental Health Worker accompanying the Winnunga Doctor on visits to Goulburn Prison as a very positive initiative. However, the current arrangement of one day a fortnight is not sufficient. The Psychiatrist has also observed that these medical visits can be difficult and inappropriate for both the Doctor and the Winnunga workers as well as inmates, as they do not have the privacy or comfort to speak (e.g. the Correctional staff stand around them with hands on hips wearing their trudgeons). This lack of privacy interferes with the ability to build a good rapport with the Doctor and discuss sensitive matters knowing they will be teased. So prisoners put on a social façade and are very emotionally shut down which belies their inner world, ergo creating difficulties for the medical practitioner to gain a true understanding of underlying needs.

The Psychiatrist's experience of visiting patients in the BRC is that there are a lot of deficiencies in interpersonal interactions, e.g. flippancy, infantilizing attitudes, as well as the venue. On one visit the Psychiatrist was put into an interview room for the consultation, notwithstanding the availability of a Doctor's room, and the sound of jack-hammers in the background. Nevertheless, the patients talk about distressing things often with insight and humour and demonstrate resilience in adversity. Although the Doctors realize they need to work within the system, difficulties can arise when a 'shut-down' at the BRC occurs (as a result of short staffing) causing a cut-off in the consultation. This is particularly difficult when attending to a serious problem such as an assessment of adverse reaction to medication. The Winnunga Psychiatrist considers that mental health (social and emotional needs and their underpinnings) are not given the seriousness they deserve (Winnunga Psychiatrist Interviewee 23, 21 November 2006).

The BRC nurse (who is non-Aboriginal) presents another view of Aboriginal prisoners coping with incarceration:

'They cope very well, actually, because they try and provide them with some sort of support network, as far as whatever yard they're in, making sure that they're always with somebody. Again, if they want to be transferred over to Symonston Remand Centre in the ACT they have to make sure that there are Aboriginal people over there. Generally they can't go over there on their own, if there is no support there for them. However, sometimes some of them are quite happy to do that and the individual is looked at. But yes, they are provided with some sort of network. And they've got access to the Aboriginal Liaison Officer. She does regular visits down to the yard as well as seeing people individually in her office. She goes to Symonston but the bulk of her work is here at the BRC. The less there are out at Symonston the better, I suppose, but the thing is that sometimes quite often a few of them will be out there. Overall they're coping all right. So many of them have been around the system. A lot of them have been through the juvenile system, and they don't usually cause too many problems with the officers. They're actually quite respectful of authority and don't tend to play up, and are very, very respectful. We don't have a problem with them at all. Yes, I can honestly say that we don't tend to have any problems with them and they are very well-mannered and you can have a bit of a joke with them. I think Corrective Services are very good as far as what they will actually do for the individual, regardless of whether they're Aboriginal or not, such as getting them to funerals, getting them bail if they need to go to a hospital. Quite often if there is a partner who is pregnant and having a baby, and they will actually get them bail. In actual fact I think people would be quite surprised how compassionate Corrective Services are. And you don't hear all that positive stuff' (BRC Nurse Interviewee 09, 11 October 2006).

In contrast, an Aboriginal Parole Officer thinks that they cope -

'Very poorly – it is a double punish for them. One fellow has been in and out of institutions since he was a kid. He says 'If I go back there is no more time left in me'. He gets angry in prison and is the opposite to what I see. It is the powerlessness of it, and it impacts on his health when he is in prison. And he will ring me asking me to ring the Judge to get him out – he is perfectly intelligent. I had not seen him for 3 weeks and he looked healthier than I have ever seen him because he was off the drugs and his health was taken care of. But his mental health, his spirit is broken and there are so many things that have happened out of his control – he is so powerless. Physically he was good

but inside – spiritually he had come to a point where he was looking for new directions in his life and then got into remand, and it was one month. But it may set him back 10 years because it reaffirms his belief that he is worthless and under the control of other people. He was bailed but had to go to court again and all the obligations of visiting me, mental health and everything else, he says he can't do it. If he misses one appointment he will be breached and this is where the practical help would be good. All his life someone has told him what to do and if there is no one at home to say 'You must go to this appointment'. There has always been external direction not internal direction to do this - and it is impossible for him. I hate going there because of the pain of his sexual assault which he probably had to deal with as a kid'.

'You are fighting education – no one I know has gone past Year 9 but the problem more is being taken. Young people live with their parents and they don't understand the grief of their parents of being separated. There is a tendency of young men to say, 'We are tough' but they are suffering every day. There are such bonds in families like one fellow has two brothers in prison and he said, 'I have been there to make them feel better'. They feel guilty when they are not in there and I have suspected one has done crime because brothers have been in there by themselves. Some respond [to family crises] by cutting off. [Then they say] 'I don't want to know. Let me go with the routine, [of prison] then I will worry about it'. [Or] if auntie has my daughter and she is sick and I have to scam my way around to get a phone call, and people call me a manipulator because I have to scam ...'. That sort of thing. This is from a mother's point of view. We had someone die last year and his brother was not allowed to attend the funeral and we can only guess at the long term grief at that. Knowing the rest of the family were there and they weren't' (Aboriginal Parole Officer Interviewee 12, 4 October 2006).

12.6 Mental Health and Corrective Services' Culture

The ALO at the Belconnen Remand Centre draws a comparison between the needs of remandees and prisoners regarding education courses and rehabilitation programs. The ALO considers that remandees are unable to concentrate on education courses in remand and participating in courses '*is the last thing on their mind*'. Their needs are associated with drug and alcohol assessment and rehabilitation and a coping program. They are also concerned about their next court appearance and would rather be active. Out of 60 remandees only a few participated in a recent computer course. However, the

Aboriginal remandees participated in the four weeks of NAIDOC activities that the ALO organized when they did art and leather work (BRC ALO Interviewee 15, 18 September 2006). On visits to the remand centre a Drug and Alcohol Worker from Gugan Gulwan Aboriginal Youth Corporation has been particularly concerned about the lack of activities for female inmates (Interviewee 20, 18 October 2006).

The BRC Doctor and the BRC Nurse also comment on the current situation regarding the availability of courses and programs in remand, and the opportunities in the new ACT Prison when remandees will be housed with sentenced prisoners.

'There have been various levels of availability of courses. There is an activity officer but this is seriously under resourced. I don't know what the current availability is but there has been computer related courses and woodwork and craft, and there are Drug and Alcohol Workers there who talk a little bit about drug dependency and different ways of dealing with that if they wish. As far as learning to read or studying for tech or Uni courses there is nothing as far as I know. I think there is a desperate need for it but also being a remand centre it is very hard to learn much in the time they are there because most people on average are there for months. And by the time they go through the 1 or 2 weeks of detox and start getting their life in order and start getting used to the routine and focusing on how they are going to approach court when it comes around, there is not a lot of time. I can't imagine any course being able to deliver very much useful in that time. That does not mean I think it should not be available. Even if they can learn a small amount in any direction or learn that they can learn, and identify some learning needs, and find out where they can satisfy those needs when they go out I think that would be valuable for them, but there is not a dedicated officer there' (BRC Doctor Interviewee 16, 13 September 2006).

'We don't provide any group education. That's done by Corrective Services. The Alcohol and Drug Workers do it. So our health promotion and education is more on an individual, opportunistic basis in the clinic. However, sometimes in summer we go out into the yard and warn about heat and so on, because they leave their milk and their orange juice in their cells overnight in the heat and it goes off. We talk about keeping cool, and using sunscreen. We do do a bit of a health promotion out in the yard in summer, but overall, we don't have time. Remember there's only one Nurse in that clinic, doing everything, so there's not the time for group activities. But with the new prison that should

change. There will be some time for that' (BRC Nurse Interviewee 09, 11 October 2006).

The Aboriginal Prisons Project Officer, NSW Health Services provides a different perspective on prison education courses and rehabilitation programs:

I have a whole heap of theories on that one, but they're not scientifically based. But certainly your Maths and your English are important, your written work, but really who wants And the boys take them up because they're bored, but who wants to really do a forklift driver's course or, what's it called, the Green Card. They're crap courses just to keep them happy. And they come out and they say, 'Oh, we've got these courses. We can get a job'. And they don't have the skills to get a job. They would be better off ... I mean, New South Wales has a few, very few shops where they can actually start to do trades. There's welding and spray painting and a few where they actually learn a trade. I think those hands-on employment skills are better than doing academic. Not to say that they shouldn't have them offered, because they should, but if you're 30 and you've been able to survive life without being able to read to a Year 12 standard, then why are we trying to make them read to Year 12? You know? We should be making them more comfortable with getting through life. And with job skills and actually being in a work environment, you learn by associations. So you learn your English. Your written skills will pick up, because that's just the nature of being surrounded by people. So I think really we need to look at employment skills – or life skills, you know? Some bloke has never cooked Wouldn't that be a basic start? Bigger English' (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October 2006).

A Winnunga Health Worker provides another perspective:

'From what I gather, some prisons have got excellent programs. They're short term, they're achievable, and they get a certificate out of it. The other thing that they're often directed to go to while in prison is anger management, and drug and alcohol counseling, but it's just not culturally appropriate. Yeah. I think in a cultural sense, when you're talking about anger management and relapse prevention and that sort of stuff and drug and alcohol education the teacher has to know the background, and ideally be Aboriginal. And if it's not an Aboriginal person, it's got to be done in a collaborative way – with the person, not a confrontation, because it doesn't work. Some of the old methods of relapse prevention and anger management don't work. The more modern approach of motivational interviewing and brief intervention, which is the

model of interaction I use, is quite collaborative. Well, it's how Nurses work anyway – well, a good Nurse. 'Come in. What have you come to see me for?' That's one model of how to do it (the motivational model). The other one I tend to say is, 'What do you want to do?' And then you say, 'Well, how confident are you of getting that?' And you talk about a range. When someone says to me, 'I'm about a 6', you go, 'Wow! That's a pretty high confidence level. How did you get to a 6?' So that's a constant reflection, and that motivational interviewing stuff, it's a lot of work' (Winnunga Health Worker Interviewee 13, 11 September 2006).

The ACT Corrective Services Parole Officer worries that there is not sufficient exit programs available in prison:

'There will be programs in prison and they are good when there is nothing to do, but they need an exit program before release to immediately go to counseling and get linked up. They should meet the counselor before release – this is throughcare. When your only mates are doing it, you feel 'If I am not doing it what will I do?' It is a family thing and everything. Relapse strategies are good but it is backing off post release that is important' (ACT Corrective Services Parole Officer Interviewee 12, 4 October 2006).

The BRC Doctor comments on the benefits of employing prison Aboriginal Liaison Officers:

'Sometimes I don't see the Aboriginal Liaison Officer for weeks on end and I am not sure how many hours a week the ALO works and the ALO also has two venues, Symonston and BRC. And the ALO's time is fairly stretched as well. But when the ALO does come it is great to have the ALO at the meeting. Every Wednesday there is a meeting, the Detainee Review Committee Meeting with a Psychologist, Welfare Officer, Nursing staff, myself, that's all. They all come to that and discuss. Anyone who seems to be at risk we need to talk about that. We need to tell everyone they need special care or observation, and it is great when the ALO can come to those and give us a perspective that we might not otherwise have about Aboriginal perspectives' (BRC Doctor Interviewee 16, 13 September 2006).

An overwhelming number of representatives of the support organizations considered that the BRC ALO carries out a valuable support role for the remandees. In this regard, the Marumali Healing Program representative (Interviewee 11, 15 October 2006) through healing work in prisons has observed that employing ALOs results in increased prisoners' wellbeing in

their connection with the outside. However, the Marumali Healing Program representative considers Aboriginal prisoners can pick up very quickly if the person helping them is not sincere. According to the Nannies' Group, this appears to be occurring in Goulburn prison with a newly appointed ALO. The Group considers that Winnunga interaction with ALOs would result in increased wellbeing within the prisoner population and the ACT community (The Nannies' Group Representative Interviewee 05, 13 September 2006). The issue of the requirement for both male and female ALOs was also raised by respondents, and ensuring they do their job was considered another issue: *'But you've got to make sure that they do their job. You can't put a job in as a token and then expect the boys to be happy, because it just pisses them off'* (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October 2006).

A Winnunga Drug Health Worker further emphasizes the value to the community of prison ALOs when they perform their role correctly: *'Probably not enough Aboriginal Liaison Officers. Often they're not acceptable – not for their own ... it's just that the structure of the prison doesn't allow them to have very good access. Certainly families, when they're trying to ring Aboriginal Liaison Officers in the prisons have a hard time getting through; they've said that. 'We can't get through' or they'll ask one of the Aboriginal Health Workers, who can get on the phone and say, 'Oh hi, I'm from So-and-So'. You've got the capacity, the phone, and the time to push. But when a family member rings up and says, 'Oh well, I'll leave a message', they get pushed away really easily. So a lot of that advocacy is really important. Yep. So it's for a family to have enough – for starters the resource for a phone, the energy to get up there and ring – and then be told no. I know at the moment families lose contact where their families are, because as you know they're moved around the State'* (Winnunga Health Worker Interviewee 13, 11 September 2006).

In Goulburn Prison the prisoners are segregated by race to keep gangs separated and for prisoners' safety. In other prisons such as Junee Prison, having strong group leaders among prisoners is discouraged (Winnunga Health Worker Interviewee 03, 18 October 2006). The general respondent consensus was that segregation should not be encouraged in the new ACT Prison, but if prisoners wish to be together they should be able to do this.

12.7 Perspectives of Prison Health Services for the ACT Prison

Based on his experience in delivering primary health care to inmates of the BRC in the ACT, and Goulburn and Cooma Prisons over the last eight years, the Winnunga Doctor's (Interviewee 17, 23 November 2006) views on the health services and programs for Aboriginal inmates, which should be included in the new ACT Prison are summarized as follows:

Currently, it would be difficult to provide more than one session a week in the new ACT Prison, and Winnunga needs to maintain services to Goulburn and Cooma Prisons in NSW. A lot of people in prison are from the South Coast. If people from the ACT are caught and sentenced in NSW they are incarcerated in NSW prisons and it would take some time to obtain a welfare order to have them transferred to the new ACT Prison. Consequently, if people are tried in Queanbeyan they will go to a NSW prison. Therefore ACT prisoners will still be spread around NSW. Currently NSW Health pays for the Winnunga Doctor, the Aboriginal Health Worker and transport costs to visit Goulburn and Cooma Prisons.

It is very difficult to estimate the number of sessions Winnunga should provide per week in the new prison. Four hours should be enough. One half hour consultation with the Doctor is not necessary. The Doctor does not need to be with the prisoner all the time. Fifteen minutes is adequate, and then the Health Worker talks to the prisoner. One session a week for each person is adequate. Future requirements for the new ACT Prison would include one Health Worker working with the Winnunga Doctor, plus two more Health Worker sessions per week. Currently, Health Workers go out to the BRC, however these visits should be more frequent. Apart from the medical services provided it is also appropriate to have Aboriginal Health Workers visiting and talking to people.

They are more comfortable talking to another Aboriginal person. When the new prison is built Health Workers could go independently of the Doctor. There should be a good connection between the Health Workers and the prison health staff. There should be a separate mechanism where Health Workers visit the prison to communicate with the ALO.

Currently there are no resources for the Winnunga Psychiatrist to visit the new prison regularly. The low number of female Aboriginal prisoners does not

require a female Winnunga Doctor. The Winnunga Doctor sees women at the BRC and there is also a female doctor who attends the BRC. An Aboriginal Dentist would be preferable, however Winnunga has been unable to arouse community interest in visiting a prison.

Regarding health services provided by Winnunga on release, advice on Aboriginal people's entry into prison is available to Winnunga, but Winnunga is not advised when prisoners are about to be released. Consequently, the Winnunga Doctor sees former prisoners at Winnunga only if they decide to go to Winnunga.

The prison health service for the ACT Prison should be provided by ACT Health not ACT Corrections. Winnunga should offer testing for hepatitis B, C and HIV with appropriate counseling for prisoners. Hepatitis C is very common and the initial management is monitoring, with a liver function test every three months which should be done. If the decision is made that treatment should be done, it should be offered with the assistance of the Gastroenterology Unit at the Canberra Hospital. And it should be possible to treat people as it is in the NSW prison system. A self-injecting room is something which should be considered. The results from the Sydney injecting room seem to be dramatically good. A lot of drugs are used in the prisons, and it is unknown how they get in. A tattoo parlour is a good idea and it is possible to air brush tattoos (Winnunga Doctor, Interviewee 22, 17 November 2006).

An Aboriginal health worker in Port Philip Prison in Melbourne provides his views on the holistic health services model for the ACT Prison:
'A Psychologist service would be good [in the ACT Prison] because they would come out as clients of Winnunga. The Psych should have four hours a week and the Doctor from Winnunga should have a day a week, then a Health Worker and even a drug and alcohol person. They are all important. There should be consistent medical visiting each week. Someone from the Hepatitis Council would be good about managing it. They can get blood tests when they go into prison. Some say they have hep C and don't need to be checked. Also access to a diabetes educator is needed' (Aboriginal Health Worker Port Philip Prison Interviewee 01, 19 October 2006).

When other support organizations respondents were asked about the health and wellbeing services which should be provided for Aboriginal prisoners in the new ACT Prison, their concerns were mainly about mental health, drugs

and detoxification facilities, throughcare (release arrangements) and reducing recidivism, ongoing cultural awareness training for Corrective Services' staff, building good support organization communication links, and Winnunga having a critical role in delivering holistic health services.

The ANU Drug and Alcohol Researcher provides his view of prison health services for Aboriginal inmates in the new prison:

'The health services should be managed and operated independently of the Correctional authority, not subject to its direction. In many cases community controlled health services are not capable of providing the same quality of care because they get so little resourcing compared with the mainstream system. In every Aboriginal Medical Service in the country they have to pick up where the mainstream system has left off. There is a long history of that at Winnunga. Professional health services for Aboriginal prisoners should be provided within the framework of the Correction health service. Winnunga will have a critical role, but they should not be responsible for all the health care services to Aboriginal people. That would be a cop out for the ACT Corrections and ACT Health' (ANU Alcohol and Drug Researcher Interviewee 07, 23 October 2006).

The following sections present support organizations' perspectives on issues of the ACT community interaction with Aboriginal prisoners of the ACT Prison and their families. These sections consider Winnunga's perceived role, the role of the ALOs, and ways of addressing prisoners' mental health and drug issues in the ACT Prison.

12.8 ACT Community Interaction - ACT Prison

Human rights and contact with the Aboriginal community are aspects of prison life that the Manager, Indigenous Services, ACT Corrective Services considers important in the new ACT Prison:

'We will have an Aboriginal Liaison Officer and Indigenous officers (where possible) in uniform. I came through as a uniform officer along with 5 other Indigenous officers, which had a positive impact with the Koori inmates. They were just so happy to see a black face in uniform and it took away the edge and made them feel welcome. When you are dealing with people who are institutionalised and are incarcerated they need support. A lot of people understand they have done the crime and they get punished for that, but they don't need to experience further hardship' (Manager, Indigenous Services, ACT Corrective Services Interviewee 04, 12 September 2006).

A South Australian Corrective Services Executive Officer (Interviewee 19, 17 November 2006) considers that community people could provide a male and female Elders' program for prisoners that would cover respect, anger management, and wellbeing. The Elders should be community members who have brought up their children to achieve and have kept them safe. They would also be involved in throughcare on release in the areas of assisting with schooling and parenting programs.

The Manager, Indigenous Services, ACT Corrective Services representative has similar views on Elders' involvement:

'I think there are a couple of missing links and the important one for me is we need to look at one's wellbeing. It is not the bloke with the broken leg we are talking about it is the soul. What some of the other jurisdictions do is involve the Elders – they come in and talk to them and maintain that link and cultural contact to keep that cultural spirit in good shape. You find a lot of Indigenous people are hurting and no one knows about it. And it might be having the Elders come in and talk, or do artwork, or other cultural activities. Just meeting and listening can help inmates get things off their chest, and they have difficulty doing that other than with an Indigenous person. You need community input, which needs to be formally recognized as part of the healing and wellbeing, and part of a person's healthcare.'

'Talking about health is very personal and it is about building up trust in someone, and that is not an easy thing to do. It humanises the process and makes people feel good about themselves, and to me that is good therapy, and sometimes that is all it needs to pick someone up. They need various types of support and linkages i.e. linking to the community. Sometimes, it might be as simple as picking up a paint brush, having a chat, or a coffee and a relax. You talk to detainees and they open up and we have a laugh and a good yarn, and that is so good for the soul and we need to encourage and develop these types of activities. This might be drawn out through education courses such as running a language class' (Manager Indigenous Services, ACT Corrective Services Interviewee 04, 12 September 2006).

A worker at The Connection also considers that Elders' involvement would relieve the stress of prison as would athletics and skill programs. Health care including dental care *'need to be pushed'* to the extent that Winnunga can visit the new prison on a weekly basis. There are opportunities for The Connection and Winnunga to collaborate in advocacy and support for recovering drug

users to better assist prisoners and ex-prisoners and their families (Worker, The Connection Interviewee 02, 14 September 2006).

A representative of Circle Sentencing, ACT Magistrates' Court also has an extensive role in mind for Winnunga in the ACT prison. The representative considers that Winnunga should have a full-time presence in the new prison as well as the new Youth Detention Centre (completion due in mid 2008) so that arrangements can be made for prisoners post-release. A Winnunga bus to collect them and the option of accommodation at a half way house would be ideal for homeless people on release. Winnunga should be very much involved in the new prison including the initial assessment of people entering prison, and with the Circle Sentencing as a conduit to help the wellbeing of people going through the system. The representative has already established strong communication links with support organizations including Winnunga, the Rape Crisis Centre, the Crisis Centre for Men, and Gugan Gulwan Aboriginal Youth Corporation (Circle Sentencing Representative Interviewee 24, 5 September 2006).

The Gugan Gulwan Drug and Alcohol Worker also considers that strong communication links are essential, especially between Gugan Gulwan, Winnunga, legal services and drug organizations when the court decides that people require drug and alcohol assistance. This representative is called on by the court so he can explain the drug rehabilitation procedures to families. The representative is on the Steering Committee for the Aboriginal healing detoxification Bush Farm in the ACT. The Farm would accommodate domestic violence and drug and alcohol rehabilitation. Village type accommodation would be included for males and females, and people from the region could access its services. Karralika in the ACT is a strict program of abstinence, and not all Aboriginal people want to do rehabilitation there or are able to cope with this type of program. Additionally, many detoxification centres will not accept partners, with the result that when partners are both drug users they cannot always go into rehabilitation together. It is quite common that while one partner is in detoxification the other gets back on the drugs (Gugan Gulwan Drug and Alcohol Worker Interviewee 20, 18 October 2006).

12.9 Aboriginal Liaison Officers' Role – ACT Prison

The interaction between Winnunga Health Workers and the ALOs was seen as crucial for health and wellbeing in the ACT Prison. A South Australian Corrective Services Executive Officer provides the benefit of experience as follows:

'You need to grow partnerships between the Aboriginal Health Service Doctor, Aboriginal Health Workers, and the other health services people in the prison. It is important that there is agreement between the community and the prison that the Aboriginal prison health is employed by the community to work with the prison health teams. You need a few Aboriginal Health Worker teams comprising males and females. One team should be in the prison all the time and the other in the Aboriginal Health Service. Rotating them is important for preventing burnout. Having a team in the prison creates partnerships with medical people as well as the Aboriginal Liaison Officer. This is a good model because such a partnership would keep all stakeholders informed' (SA Corrective Services Executive Officer Interviewee 19, 17 November 2006).

The BRC ALO agrees with this model. The ALO considers that Winnunga's Aboriginal Health Workers and Drug and Alcohol Workers should work with the ALO in the new prison. The ALO currently has management meetings with the workers from Gugan Gulwan, Winnunga, and Circle Sentencing. However, more involvement with Winnunga is required (BRC ALO Interviewee 15, 18 September 2006). The Manager, Indigenous Services, ACT Corrective Services confirms the importance of the role of the BRC ALO:

'We have the Aboriginal Liaison Officer at BRC. The ALO does a fantastic job there and works well with Indigenous inmates, who rely heavily on the ALO. I'm sure if you had an Aboriginal Doctor, Nurse or an Indigenous health liaison officer, they would be the first ones the Indigenous inmates would go to. That sense of wellbeing comes from this interaction. There is a sense of isolation and loneliness and lack of support and it is much easier for an Indigenous person to speak to another Indigenous person generally speaking. They live with each other. It is a communication issue. That is the ALO's strength' (Manager, Indigenous Services, ACT Corrective Services Interviewee 04, 12 September 2006).

One instance of incorrectly utilizing prison ALOs occurred in the Port Philip Prison:

'There is one [Aboriginal Liaison Officer position] which is contracted full time. Port Philip could not get this right. The managers of the prison employed an Aboriginal person to look after fellows [in the Liaison Officer role] and act as a prison officer on alternative days, as they did not see the role of the Liaison Officer full time. So the role was to say: 'What are your problems?' 'Now goodbye, I have to lock you away'' (Aboriginal Health Worker Port Philip Prison Interviewee 01, 19 October 2006).

This demonstrates the difference between the role of the ALO and a prison officer. ALOs are on call 24 hours a day and manage issues such as the inmates' classification, funeral leave, and inmates' phone calls. They also provide advice to prison officers about a particular person's management (Aboriginal Health Worker, Port Philip Prison Interviewee 01, 19 October 2006).

12.10 Mental Health Issues – ACT Prison

On the issue of prisoners' mental health Directions, ACT considers that:
'It is hard in prison not to get distressed. But you need professionals that prisoners can trust. You have to build a good rapport with people before they will open up and for some people it is like a shame thing - they have so much stuff going on. Good to have groups for men so they will open up. Victorian prisons have listeners for this purpose' (Aboriginal Support Counselor, Directions ACT Interviewee 21, 20 October 2006).

A Winnunga Health Worker who accompanies the Winnunga Doctor to Goulburn and Cooma Prisons has observed that:

'It is important that Indigenous health services are available in the new prison, as sometimes this is the first chance Aboriginal people are able to see a Doctor. A Dentist from Winnunga is very important because of the terrible problem with teeth people with mental illness and drug users have. There are no dental program services in the community now. Literacy programs are also important. Winnunga's Healthy for Life initiative of total individual health checks would assist the incarcerated and increase community health. Health care for women prisoners is important i.e. peri- and post-natal care, routine health screening, pap smears, and diabetic checks. Overall, the more Aboriginal services in the new prison the better for the prisoners and the whole community. Aboriginal Liaison Officers are also important' (Winnunga Health Worker Interviewee 25, 31 October 2006).

The Winnunga Psychiatrist also emphasizes the importance of the ALO in assessing the mental state of prisoners. The Psychiatrist considers that there could be occasions when a Psychiatrist might need to go into the new prison to see people that the Winnunga Doctor thinks are complex enough for further specialist intervention, but in a culturally correct way in order to ensure the prisoner's psycho/social/cultural needs are addressed:

'Once people get to a psychological bursting point they have trouble containing themselves and lose the ability to either contain their emotional world or clearly process and articulate their needs. Appropriate time and place are required to manage this, and often the help of an Aboriginal Health Worker from a similar culture is experienced as more appropriate by the inmate; the Aboriginal Health Worker can facilitate this process, and help to manage other issues e.g. shaming, expectations of discrimination and dismissing attitudes in others, especially within an authoritative prison context; so Aboriginal Health Workers can be critical in co-constructing a more cohesive and contextual narrative'.

The Winnunga Psychiatrist considers criminality, in general appears more impulsive than premeditated. People are either chaotic in their thinking or are trying to 'self-medicate', and often commit crimes in that context. There is a need to address drug and alcohol detox rehabilitation but especially in the light of the underpinnings of substance abuse and dependence. Appropriately addressing biological, social, psychological, cultural, historical and spiritual needs in treatment while people are on drugs and alcohol means that after a while psychological abilities supersede the 'needs' supplied by drugs and alcohol. The prison system would benefit from following this protocol while providing sufficient encouragement. The encouragement comes from the interpersonal relationship with inmates that gives them a sense of confidence. This happens over a protracted period of time so they can receive the grounding they need within the restorative justice system. The community can also offer practical interventions in the prison such as culturally appropriate group work designed by such organisations as Winnunga. For example this could involve writing a sorry note to the victim setting out how the victim might have felt and how they (the prisoner) might have felt. Regular interaction with the Winnunga community, which includes a more holistic management, is very important in helping the transition of those who are emotionally unstable and anxious (Winnunga Psychiatrist, Interviewee 23, 21 November 2006).

The ACT Corrective Services Parole Officer is of the opinion that Aboriginal Health Workers' assistance in crisis intervention for mental health is necessary. There should also be services addressing grief counseling and childhood trauma which the representative suspects is the source of the drug use and self harming behaviour. It is also important that programs in behaviour management and reintegration into the family be available. In addition, the relatives who are caring for the children of prisoners, or single parents need to be provided with transport to the new prison (Parole Officer, ACT Corrective Services Interviewee 12, 4 October 2006).

The Nannies' Group considers that there should be consistent follow-up and contact by Winnunga staff when prisoners are released, particularly if they have been seen by Winnunga staff for mental problems when incarcerated:

'In a crisis situation you are told they have to have done something before mental health can do anything. And being told that and losing your kid a couple of weeks later [through suicide] by the way he was threatening – I wonder how much assistance white kids get when they come out. The BRC say they do not have facilities to assist people with mental health issues. They are not qualified other than recording self harm and what they see and putting them in a cell. They call in a mental health crisis team who are always reluctant to do anything to help. This is where we should be able to rely on the services of Winnunga to do these things for us' (Nannies' Group Representative Interviewee 05, 13 September 2006).

The Nannies' Group considers that Winnunga is there for the Aboriginal community and they have the right to expect that Winnunga will provide the services that they get funded to provide to them. They ask:

'Why should we go to Tuggeranong Health Clinic because we are dissatisfied with Winnunga who should clean up its act and get all the services they are supposed to be providing up and running in a proper and professional manner so the community are comfortable and feel safe in knowing we can go to Winnunga and get what we need? This concerns all families in the ACT. Winnunga is set up to help people like us. It needs well qualified people, and outreach which follows up on our cases to take off a lot of stress and strain from families with potentially suicidal children. We will never be fully out of that stress but professionally trained people can help. Families need training so we will know what to do when professionals are not available. The behaviors of the mentally unwell are sometimes so awful that we do not know how to cope, and some of their behaviours can be very daunting to someone

who has never experienced that' (Nannies' Group Representative Interviewee 05, 13 September 2006).

The ANU Drug and Alcohol Researcher comments on the incidence of co-morbidity of substance use and mental health in prison:

'Prisoners are incredibly stressed. Most of the drug use in prisons is self medication to cope with prison stress. Because they don't get a regular supply of drugs and consistencies, prisoners are not able to sustainably self medicate. It is a big issue and obviously the co-morbidity of substance use and mental health is a significant issue. There is greater attention on the epidemic of stimulant use. This has increased attention on the co-morbidity conditions. There is no longer any justification for separate Corrections mental health services and Corrections substance abuse services. You can't differentiate. With the right staff you can work in that area. It is very, very difficult in the community and incredibly challenging. One of the real tragic things of our health care services in prisons is the lost opportunity for making prisoners healthy i.e. immunizations, diets, how to look after themselves, mental health, stress – there is so much that can be done to teach them to take responsibility for their own wellbeing. The Bush Farm [Aboriginal detoxification centre] has been on the books for a number of years. There is supposed to be a report completed about it but I have not seen the report yet or proposals. That was one of the recommendations of the Drug Report completed by the ANU. In the new prison there should be overall quality of service, the same as mainstream' (ANU Drug and Alcohol Researcher Interviewee 07, 23 October 2006).

12.11 Drug Issues - ACT Prison

The following support organisation representatives provide their perspectives about individual and community preventative measures associated with drug use in prison. The Aboriginal Prisons Project Officer, NSW Health Services considers that:

'My big thing is hep B shots. And in New South Wales anyway there's a whole debate about who gets a hep B shot. Now, anyone that works as plumbers in the prisons get it, and cooks get it. In the strategies it says that Aboriginal people should be given hep B shots, and I think that they should be giving them to everyone, because hepatitis B is becoming a problem. HIV is becoming a problem in Aboriginal communities too. TB is another one that is on the rise. So that's in my little portfolio. Chlamydia has always been there. I would like to see better screening'

'When they go in. Instead of beating around the bush, or not even offering it, when they're coming in, you know, give them the choice but give them a positive push in the right direction, you know? And on their release, who's going to say that the same tests should not be given on their release? For the community sake. And people will hold the prisons accountable. Let's just say chlamydia, let's take an easy one. If you get chlamydia in prison because the standards ... you know, men will have sex with men in prison in an institutional sense, but if you get chlamydia there that means that the systems inside aren't working to protect you against that. So as health workers we can use that. God forbid if we can prove that somebody gets hepatitis because they go in there. So I think that helps not only them, it helps us as health care workers to help the community. So I'm a big fan of testing, testing and testing them. And let's face it, chlamydia, two pills, or a pill, depending on what strain they've got and how bad they have it, it's really simple. So let's do what we can. Let's test, test and test, and try to get some facts and build up some true data, and then lobby where we need to' (Aboriginal Prisons Project Officer, NSW Health Services Interviewee 10, 9 October 2006).

A Winnunga Health Worker considers that:

'Probably sexual health stuff [is important]. And they could do better on the blood-borne diseases stuff, the hep C stuff. Condoms the same. The one thing I remember seeing at the BRC one day was this big bottle of bleach down the corridor and I said, 'Oh, what's that for?' 'That's for if they want to clean their fix'. Oh look you need needle and syringe program in prison. The international study on needle exchange in prisons overwhelmingly showed that. Instead of saying, 'Oh, we don't encourage any use, it's not correct'. It is actually an opportunity to say, 'Well, you know, if you still need to use ...' It does actually engage with the client or the customer or the inmate or whatever you call them. 'If you want a needle ...' and have a yarn. Why should they be denied any service just because they're incarcerated? Oh, the pressure on the families is terrible' (Winnunga Health Worker Interviewee 13, 11 September 2006).

12.12 Organizational Support for Families of Prisoners

Support from families and community organizations for Aboriginal prisoners is critical to their physical and psychological health, and reintegration into the community. Corrective Services provide opportunities for families to visit, and funding for travel is made available through Prisoners' Aid in the

ACT. Telephone communication from the detainee to the family is another means to interact. However, families experience numerous difficulties when a family member is incarcerated. These include not having the financial means to travel and secure overnight accommodation should the detainee be located far from the family home. In these circumstances, some relocate the family home. Assisting the detainee with funds for telephone calls to the family is a further imposition on the family's income. Consequently, many support organizations and family respondents in this study have identified the need for financial assistance for overnight accommodation for families visiting NSW prisons and vice versa when visiting inmates in the ACT Prison. Locating ACT prisoners sentenced in NSW in nearby prisons assists the family in supporting them. Future support in this regard could include the ACT Government's Support Assistance Accommodation Program to accommodate families visiting inmates in the ACT Prison. The BRC Nurse provides some understanding of the situation when families visit relatives in the BRC:

'For a visitor life is very, very difficult emotionally. A visit has to last an hour, for security reasons, so you might just be going to see somebody for 10 minutes but you can't, you're supposed to stay. A nice pleasant visit for some people could end up being too long. Imagine being there for a whole hour if you have nothing to say. And the other thing that happens with visits, you might be visiting someone, and someone else is visiting, and that other person has got relationships going on on the outside, and a quiet little visit can actually get a little bit hot' (BRC Nurse Interviewee 09, 11 October 2006).

Aboriginal prisoners' families are supported by a variety of organizations in the ACT which include the Salvation Army providing food, clothing and furniture; Centrelink providing welfare payments; and the BRC providing health, welfare or medication information about the detainee (with their consent) (BRC ALO, BRC Nurse, BRC Doctor Interviewees 15, 09, 16, on 13, 18 September, 11 October 2006). The Connection supports families in providing programs including the Mobile Mothers' Program and Nutrition for Children Program, and refers clients to other support organizations including the Yuarana Centre at the Canberra Institute of Technology for families wishing to embark on TAFE courses (The Connection Representative Interviewee 02, 14 September 2006). The Corrective Service Parole Officers also liaise with families of prisoners prior to their release to discuss their post-release commitments (Parole Officer, ACT Corrective Services Interviewee 12, 4 October 2006). Prisoners' Aid helps homeless families locate accommodation while the partner is in prison (Prisoners' Aid Representative Interviewee 26, 11 July 2006).

Winnunga's holistic approach provides primary health care and social and emotional wellbeing (see Chapter Seven). Of particular assistance to families of prisoners has been the Women's Group, yoga sessions, the Parenting Group, the Carers' Group and the Black Chicks netball team. The netball team has been established through the women's group to keep young people from committing crime (Winnunga Health Worker Interviewee 06, 14 November 2006). The community Nannies' Group supports partners of relatives in prison in accessing support organizations (Nannies' Group Representative Interviewee 05, 18 September 2006). The Winnunga Aboriginal Health Workers and the Gugan Gulwan Drug and Alcohol Worker also communicate with families about the welfare of their family member in prison, and assist families in contacting organizations which provide food, welfare payments, and housing. Winnunga also assists families with court appearances. The Winnunga Health Workers have an important role in advocacy, and educating families about mental health and raising awareness of community support (Winnunga Health Workers; Gugan Gulwan Drug and Alcohol Worker, Interviewees 06, 25 & 20, on 14 November, 31 and 18 October 2006).

12.13 Organizational Support for Prisoners on Release

Winnunga assists prisoners and their families on release with primary health care and social and emotional wellbeing in the areas of mental health and drug and alcohol counseling and contact with organizations supplying housing, food and furniture. The ACT Corrective Services are also involved post-release should they have parole commitments where they are required to report to their Parole Officer at certain intervals and where applicable participate in mental health and drug and alcohol programs. The study respondents identified the need for a community support network to provide support for prisoners and their families on release. The type of support identified includes support in carrying out pre-release planning which would include arranging paperwork for identification required for one week's Centrelink payment, and arranging suitable accommodation, and employment with organizations employing ex-prisoners prior to release. The total post-release assistance nominated by the respondents includes collecting prisoners from prison and providing extended practical assistance in obtaining accommodation and assistance with reintegration into the family and community, meeting all parole commitments, and arranging ongoing Centrelink payments, job training and employment.

A South Australian (SA) study of prison continuity of care and post-release priorities found that 73 per cent of Aboriginal prisoners in the Adelaide Remand Centre anticipated that they would have no accommodation or insecure accommodation on release (Krieg, 2006). As a result of this study, the SA Nunduwarrin Yunti Aboriginal Medical Service Doctor (Interviewee 22, 18 November 2006) considers that on release ex-prisoners require housing and help for a year through outreach, and advocacy assistance to keep parole and other commitments while they are adapting to life in the community. The housing would be classified for high or low level outreach, and could also offer homeless people opportunities to remain in this accommodation. This would curtail domestic violence and increase the opportunity to maintain commitments such as detoxification programs and mental health treatment.

The concern about homelessness on release is also evident through this study's support organization respondents' perspectives as follows:

'Homelessness on release is disruptive such as moving in with mum - and there may be other kids, and that can be very disruptive to the people living in that house. There is need for an Aboriginal half way house - like the one in Rockhampton - for 3 or 6 months which works in with the outside work they may be doing already through prison transition. This would also help homeless people. In ordinary circumstances relationships can be strained on release and after being home for 6 months the ex-prisoner male then decides he is going out to get drunk' (Nannies' Group Representative Interviewee 05, 13 September 2006).

'A lot of them come out they don't even have anywhere to live. When they come out they are on the street - what do you do? They pick up with someone who uses so they can find a bed for the night. Hostels would go well. Now there is nothing. They talked about this [in the past] having hostels for prisoners to come out and slowly come back into the community. Nothing happened. The ACT has hardly anything here. A lot find it hard coming out of prison because they are used to the routine' (Aboriginal Support Counselor, Directions ACT Interviewee 21,20 October 2006).

'Well, to have throughcare is important. I don't know whether outreach and throughcare are the same thing, but if you start the care, if you start any care, any program in prison, it's important to continue that when you get released. I don't know how the ACT are going to run their prison health, but in New South Wales that's run by Justice Health, so as soon as they're released there's

no follow-through, there's no throughcare. So they're dropped like hot cakes. I mean, a typical example is the quit smoking. While you're inside, the boys will be given gum and patches. As soon as they're released, they don't get any of that. The Correctional Centre Release Treatment Scheme (CCRTS) in NSW are supposed to work with them up to six weeks before release, and a year after release. It falls short in a lot of areas, but at least they're trying. Well, the CCRTS is run through Justice Health but it's supposed to work with the AMSs, to link them back in. That's where it falls down, because it doesn't do a very good job of that'.

'To my way of thinking, parole lets the system down. Once again, well, it's a trapped audience. They're mandated to go to see their parole, and parole Probation in New South Wales work on things like domestic violence, but they won't touch general health. They may do fitness; you know, they may do a whole range of things, but they don't touch transport. To me they should be developing programs where it's holistic, you know? Your housing needs are met, if you've got a temper then that's addressed, your health is addressed, you know? And they shouldn't be on this high horse - 'We know what we're doing and we don't need any help'.

'They're truly dumb. They are. I mean, Probation and Parole are supposed to pick them up, but all they're interested in is worrying about whether they're re-offending and meeting the restrictions the courts have put on them. It is mainly fronting up for their appointments. They'll try to do drug and alcohol, but all they'll do is push it back onto their health service. They'll get somebody or they'll order them to go and see the drug and alcohol service. There should be ... once you're on probation and parole you have to go and see the Probation and Parole Service. But the Probation and Parole Service shouldn't then be saying, 'Well, you go and see X, Y and Z'. They should be bringing them in to Probation and Parole, and saying, 'Okay, you're here. This is what we want to do, and this is what we've organized as a case plan'.

'You know, you've just been released from prison, you usually don't have a car. The amount of people that drive unregistered cars because they just don't have the money, you know? And we're telling them, we're encouraging them. The other thing is we need to get a lobby group going – for Aboriginal people in general. If you're looking at Aboriginal people, a high percentage, in New South Wales the percentage of Aboriginal men incarcerated is around 34 or 43 per cent. That's a high percentage of any one group, considering it's 8 per

cent of the population. So a lobby group for good conditions for Aboriginal people. It's only 8 per cent of the population, but if that 8 per cent banded together and all worked as a team, then you'd have a lot of weight. But at the moment we're different factions, and it's going nowhere. I think we should have an advocacy group' (Aboriginal Prisons Project Officer, NSW Health Services Interview 10, 9 October 2006).

The Manager, Indigenous Services, ACT Corrective Services outlines the plans for helping prisoners obtain work on release from the new ACT Prison: *'A prison working group is currently looking at developing programs for the new prison in the ACT. This involves other players in government and private organizations. Quest and Campbell Page have Indigenous employment programs specifically aimed at providing assistance to Indigenous people after release from prison. The Indigenous Success Australia organisation also provides employment assistance for Indigenous people. We are currently investigating employment opportunities for future ACT Indigenous offenders on release from prison. We would also like to consider possibilities of creating long term and sustainable skills to allow inmates to successfully compete in the open market. We will develop and offer vocational education and training i.e. certificate courses in a range of areas to fit people's needs and interests. We are unable to offer everything but will endeavour to meet some of the identified interests'* (Manager, Indigenous Services, ACT Corrective Services Interviewee 04, 12 September 2006).

The BRC Nurse describes the ongoing medical assistance the BRC medical service currently offers on release:

'If they go to rehab, obviously we send all their medical information that we can. As long as they consent we provide this to any non-government organization, GP or rehab. Anything that they require we will forward on for them. And of course if they go to a New South Wales prison then obviously we are in contact with the medical side of things up there, so that things that we've done here can get followed up there. But we don't follow them up on the outside. The other thing that we do is that if they have been in here and we have actually got an appointment made for them in the future – which obviously we can't tell them while they're in here for security reasons – we encourage them to ring up to get the appointment time, because quite often they don't do that. If they don't ring up we don't follow them up and say, 'Look, don't forget you've got an appointment'. You have to have a certain amount of accountability there' (BRC Nurse Interviewee 09, 11 October 2006).

12.14 Winnunga Support for Prisoners on Release

The following support organization respondents commented on Winnunga's involvement in supporting prisoners on release and in reducing recidivism:

'Well, something that really needs to ... is the continuity of care from prison into the community. I think that's something where Winnunga could play a really good part, especially from our point of view in raising treatment, hepatitis C treatment for Aboriginal people and Aboriginal inmates, and it's also been outlined in the national HIV/AIDS and blood borne virus strategy that organizations have a clear process of continuity between prisons and the community. And we're one of the key organizations that are to play a role in that. So that's something in the future that I really feel is a gap within prisons. And there's that whole issue of compliance and the likes, with treatment centres – I'm not talking specifically just hepatitis treatments there, but mental health treatments and the like. So I think there needs to be a bit of a role played there in between services. And you can't always capture everyone that's going to come out of the prison. They may go back to their locality where their family's from. But just putting some type of process in there where you can just catch up and make sure that the prisoner...' (Aboriginal Policy Officer, Australian Hepatitis Council Interviewee 08, 10 October 2006).

'I think that when you look at it the damage that leads to people leading what we might call a life of crime - but it is only a couple of decades of crime. The damage has been done many years back and you can't fix that and so anything you do is going to have ... it is more a percentage of positive outcomes. But a ten per cent reduction in recidivism I think is worth spending money on'.

'Winnunga could be helpful in this, but I don't pretend to know how without having done the research. There are probably a few things – there was an article about meditation in the Good Weekend a year or two back. Meditation was tried in some prison and made a big reduction in violence. So whether you have any connection with that it appears to be quite out of left field, but someone has done a study on it and it could be looked at and applied even if you can't explain how it happens. You can image the attitude of conservative elements in the community. But that is just an example of looking around. Mainstream things have been conferencing techniques where the victim and perpetrator have a conference and the perpetrator is confronted with the effects of their crime and develops some empathy and this has been shown to be of benefit. I have seen nothing like this happen within the Remand Centre

environment but is just an example of something that has been based on study and that is an area I am sure that if it was implemented Winnunga would have an enormous role to play’.

‘When I said a life of crime is usually a couple of decades, most of the detainees are young adults, young males and around the age of 30 they go to prison or they change their mind – they come to a different perspective on life and something happens – they don’t keep coming back. That is not universal because we have some other people there, but it is a particular age group and out of the whole life time that is a short time – so something happens – can we hurry it up? Now one of the things when people come to me and actually think they are genuinely desiring of changing their self defeating patterns, one of the things that change their perspective is kids. Their responsibility to their kids. So this suggests enormous potential for families to be supported, so that if somebody develops that attachment and sense of responsibility to their children that is enhanced by some sort of mechanism there whereby they can actually see the kids for whom they feel responsible. It is mostly fathers in there, and if they have a supported contact with their kids and develop a relationship, and have some sort of professional support in developing their parenting skills, and their joint parenting skills – their relationship with their children’s mother, if they have some support there then I imagine that would reinforce their desire to lead a life that enables them to maintain that relationship. And any effort to reform their lives has been rewarded and they can continue down that track’ (BRC Doctor Interviewee 16, 13 September 2006).

In the past Winnunga has offered several occasions for members of the community to participate in the Parenting Program through the University of Canberra. This program will restart during 2007. There have been good results from the program, however Winnunga has not had the resources to assess the progress of the participants. More female Health Workers are required to service community demand (Winnunga Health Worker Interviewee 06, 14 November 2006).

The ACT Magistrates’ Court, Circle Sentencing representative considers that Winnunga’s involvement in a detoxification centre would assist the community. This representative always ensures that Winnunga is mentioned as an important organization when briefing the Circle panel. The Aboriginal Legal Office performs a significant amount of outreach work and this is

important for the community. Many people do not ask for help because of shame. However, The ACT Magistrates' Court, Circle Sentencing representative considers that '*Winnunga knows how to elevate proudness*'. It is all about harm minimization, and reducing crime. The representative would like to see the Winnunga CEO as part of the Circle Sentencing Court Committee. In addition, the newly formed Aboriginal Justice Centre will be involved in networking and communicating about reducing recidivism. Winnunga could work with Circle Sentencing to send a bus to make sure people turn up for parole sessions and other commitments such as attending programs they need to do while under court orders. The important aspect is quality and not quantity. The representative considers that Winnunga goes for quality – unlike public service organizations in that regard (Representative, Circle Sentencing Interviewee 24, 5 September 2006).

The ACT Corrective Services Parole Officer considers that continuing practical support and outreach is important on release with connections established prior to release. This representative has observed that Aboriginal ex-prisoners have real issues in coming to terms with parole commitments. They might be in the form of not having transport or bus money, or being unable to conceive that they have parole commitments. The Parole Officer considers that Winnunga has good health services but lacks extensive day-to-day practical help. For example, young male offenders go 'haywire' in the first few months of release and require assistance with accommodation, food, reintegration into their families and dedicated Aboriginal drug and alcohol rehabilitation. Strong future relationships are essential between organizations such as Winnunga and the Aboriginal Justice Centre in providing this practical support (Parole Officer, ACT Corrective Services Interviewee 12, 4 October 2006). The Aboriginal Community Liaison Officer (ACLO), Australian Federal Police (AFP) envisages formal communication avenues between The Connection, Winnunga, Gugan Gulwan and the AFP to minimise parole breaches and to provide practical support (AFP ACLO, Interviewee 27, 16 October 2006).

A Winnunga Health Worker explained how Winnunga currently helps people obtain jobs through personal contacts, and when people in the community approach Winnunga for help. Some examples are the Winnunga Home Maintenance Program, and the Youths at Risk Program which assist those at risk and under court orders. Under the existing arrangements, during prison visits Winnunga Health Workers distribute their business cards to

encourage further contact by prisoners and families on release. The Winnunga representative considered that a half-way house is necessary for prisoners coming out of prison. In addition, Winnunga support could be improved by taking people to parole and other organizations while observing people's freedom of choice (Winnunga Health Worker Interviewee 03, 18 October 2006). Another Winnunga Health Worker considers that on release - *'it would be good to have a half way house, then housing for accommodation and someone looking at employment and other needs. We do help here but it is not our role and not something we would want to set up on top of what we have now. We would have our injecting drug users who would come to Winnunga on release and young boys with the Automotive Workshop as well at Fyshwick [the Winnunga Youths at Risk Program – see below]. They are the ones linked in with Winnunga. Or the women needing help if a family member is in prison. Specific post release service for families to refer them to services would be good – a one stop shop is needed with 1800 numbers. The network chain of these services needs to be known and the Aboriginal Justice Centre might be the catalyst'* (Winnunga Health Worker Interviewee 06, 14 November 2006).

The Winnunga Health Worker/Project Officer explains how the Winnunga Youths at Risk Program helps young people at risk while assisting their families:

'We have between 5 and 10 kids who do the program over a year. They work at their own pace – this is important for the success of the program. They are trained in automotive work, spray painting, cultural painting, entertainment and boxing. Funding support is crucial for the success of this program. The kids get trips away every 4 week if they achieve in their training – they don't get something for nothing. These trips help them to keep achieving. Individuals need time to change their lives. Last summer I had a kid who had to report to the Police Station every day and I took him there. This is a guy that hated cops. One day we went in and I stood in the background, and he called them 'sir'. This was the first time he had done this. It took him 6 months to do this. In the first months his shoulders were drooping. Now he is standing straight. He has totally turned around but it has taken 16 months to do it. However, we need funding resources and time to change people around'.

'If their parents have the support from the community they need they are in a better position to help the children. When kids see that their parents are handling situations well they will grow up confident, develop their own skills

and move on. But there are intergenerational problems which are genuine, and haven't been fixed in the past. For example, a parent might have five kids to support. They might be on the dole, and battling with the rent, food, school, and clothing. To receive outreach support for just two hours a day, or four hours out of the week is important support. And after that you get the parent out of the house and into developing her skills so that she can either take up part-time employment, or start doing something from home that can bring in some extra income while she's on the dole. At the same time we want the kids on the program to learn a little about discipline, satisfaction, and self-esteem as they are watching their mother change'.

'It is not just a quick fix. A quick fix might last for 6 or 12 months but unless you fix everything else that is residual, those 12 months are wasted because the kids go back to the same environment, because nothing underneath has changed. This is a holistic view with everybody within the community providing assistance including all organizations - private and government, professionals, Police, and Magistrates. Then they will be in a position to appreciate our program and its positive outcomes rather than assuming we are wasting our time. It means continued cooperation with the Police. I have worked with the AFP. I have been there and I have seen it while growing up in a country town. The Police are an important part with the boxing and sport. They have helped me in my life. There is also an opportunity for youth on the program to conduct courses in the new prison teaching prisoners to air brush tattoos and paint large murals' (Winnunga Health Worker/Project Officer Interviewee 28, 6 November 2006).

A Winnunga Health Worker observed that mental health requirements for prisoners on release, are currently organized by ACT Mental Health. They organize a pre-release plan for their existing Aboriginal clients and make arrangements for them to return to the ACT from interstate prisons. They also conduct case conferences about these patients, with their carers in attendance. These links with the patients and families are strong because of the commitment of the forensic team in improving the service. However ACT Mental Health continues to receive negative comments because it is not a positive area. The Winnunga Health Worker considers that making an extra effort in persuading people about their parole commitments is also important. This worker currently assists by making phone calls for them and this builds trust in organizations they need to access. Then they are able to continue to access this assistance independently (Winnunga Health Worker Interviewee

25, 31 October 2006). The Winnunga Psychiatrist also comments on mental health requirements on release:

'This institutionalized system makes Aboriginal people dependent and when they get out of prison they need some type of half-way house, like getting out of hospital; time and support for integration into the world but where they could come and go; to assess what intervenes in enabling their integration and how you might enable them to do this in a way they can manage. They want to be seen as normal, but need a transitional period to enable this interjection'.

'It will be hard to assess who will manage or not. Those needing greater support will probably be emotionally restricted in prison, losing their skills of emotional regulation during this time and requiring time and support to open up again but will manage more appropriately with a hopeful and optimistic attitude for something better in a future they can be more proactive about and have control over' (Winnunga Psychiatrist Interview 23, 21 November 2006).

A Winnunga Health Worker describes the difficulties encountered in arranging detoxification facilities on release from prison. These include lack of identification or funds from Centrelink to pay an up-front fee. Consequently, there is a high risk of failure in the absence of an outreach worker to facilitate these matters. The Health Worker adds:

'Most of our clients benefit from short-term rehab. They're not really old bugged people; they're young people who will have three months' rehab. Karralika is too structured, and the pressure on them is enormous. And it's inappropriate for our younger group. Unfortunately, it's not popular. It's quite long-term and they get in there and they go, 'Oh, my God. I can't do this. It's like another prison sentence'. And so often – oh, I haven't had to do it recently, but I've often tried to negotiate to get them to another shorter-term rehab - out of Canberra, of course. There's nothing else. And I've got men who've had a few goes at rehab and say to the Magistrate, 'Just send me to prison. I can't do that place'. There's got to be something else, though. Something short-term. Because they're fairly young, it doesn't take them long to get better again. They don't need to sit around being helped and don't want to talk to someone. They want to get out and do things' (Winnunga Health Worker Interviewee 13, 11 September 2006).

The BRC Doctor offers a final view on how support organizations might assist keeping people out of prison:

'Don't know that I have an answer for that. A few detainees have burnt their bridges with everybody at Winnunga, and with all their uncles and aunts and Elders giving them their best advice, and they have burnt all their bridges and it is a thankless task. I guess whatever can be done to prevent child abuse and I guess that involves ... I don't know if anybody knows the answer to that but certainly supporting young parents. And I know that is very difficult because young parents can be very defensive about it. But whatever can be done. A guy I met – he is not an Aboriginal – he has decided to change his life. He has been in a few times. And that is because he has a child and he wants to be a good father. And I asked him what he has to do to be a good father. He listed all the things that he should be as a good father and on the list of things he did not have a house. I think this is a very difficult job when you have a good model. With no house all he has got is a negative model. I was amazed at how much he knew about being a parent. He has had a set back and has a very long road ahead of him but if someone has an idea of what they want to be, and they have got models all around, and people to support them through that process I think that is probably of benefit. We are talking about prevention that starts 20 years beforehand. When you look at most people in there that is when the damage occurs' (BRC Doctor Interviewee 16, 13 September 2006).

12.15 Support for Winnunga Holistic Care Staff

Winnunga's support for community members in prison and on release and their family members follows Green & Baldry's (2006: 1) idea of excellence in delivering social work which is 'based solidly in and guided by Indigenous Australians' participation and experience and has at its heart human rights and social justice'. This social work or 'holistic care' as it relates to Aboriginal people, includes providing medical and social support and communicating with other support organizations.

Delivering holistic health care involves communicating interpersonally with clients and patients. Workers delivering these services, particularly holistic care prison services, face many communicative challenges within this organizational environment. They include providing medical and social and emotional wellbeing support, and acquiring operational information for decision making in external communication with other support organizations.

They are also required to remain alert to unpredictable information, for example new health initiatives such as the introduction of a prison in the ACT that could impact on future organizational operations.

The stressors of holistic care can create burnout in medical and health workers which can lead to negative psychological, physiological and organizational outcomes. The organization can assist in reducing burnout by clearly defining the employee's role, monitoring and controlling the workload and encouraging 'time outs' during the workday and time off from work to recharge. In addition, an employee's real and perceived sense of influence and control, and social support received from supervisors (e.g. job training), co-workers, friends and family can decrease job-related strain.

The work of the prison Aboriginal Health Workers can be intimidating and difficult, and debriefing and support mechanisms are important to their wellbeing. The Winnunga Doctor (Interviewee 17, 23 November 2006) considers that sufficient Health Workers should be trained for prison work so they can be rotated within a team work arrangement. This study has also examined other support organization respondents' views on their debriefing and counseling needs. Their views include undertaking regular counseling of the type to suit the individual, taking a holiday or reducing to part-time work, debriefing with co-workers or professional colleagues, enjoying leisure pursuits (aroma therapy, yoga, massage, and exercise are some such pursuits) and keeping a life balance between work and family enjoyment. Winnunga has been pro-active in engaging counselors from Relationships Australia to counsel staff on a regular basis. Formal follow-up procedures by Team Managers will ensure that the psychological and physiological needs of the Aboriginal Health Workers are met.

Chapter Thirteen - FINDINGS AND RECOMMENDATIONS

13.1 Introduction

The findings and recommendations of this study are based on the fundamental and ethical view that the penalty for a convicted person is the removal of their freedom for the period of their incarceration, and that their basic rights as human beings in our society must be preserved, and that collective punishment on their families is unethical and unacceptable in our society (Barry 1967).

13.2 Study Key Findings

The Winnunga prison health study has identified the need for culturally sensitive health programs that target early detection of chronic diseases and health promotion activities in prisons, just as the RCIADIC did 15 years ago (RCIADIC 1991). This means specific programs for physical, social and emotional wellbeing, primary care for diabetes, heart disease and other circulatory system diseases, respiratory diseases, women's health including sexual health, maternal and child health, mental health, alcohol and drug programs, and testing for hepatitis B and C and HIV on entry and release from prison, with informed consent and appropriate counseling.

Particular note was made of the prevalence of health needs relating to substance abuse, mental health, communicable diseases, and women's health. Study comparisons between Australian and overseas practices indicated the need for diversionary measures for those with mental health problems, and treating substance abuse as a health issue as opposed to a law-enforcement matter¹. The study noted that early intervention with Aboriginal women (addressing lack of education and employment) and treatment for sexual and physical abuse, mental health, and alcohol and drug abuse problems would reduce contact with the criminal justice system.

The study highlighted the limited national and international literature on Aboriginal and Indigenous prison health. However, the existing literature and data collected from 78 respondents: 22 ex-prisoners, 17 family members of prisoners and ex-prisoners, and 39 support organization representatives have contributed to developing the Winnunga Holistic Health Care Prison Model described below. The entry criterion for the study was any Aboriginal person, male and female who had previous experience in incarceration. Purposeful

¹A NSW service is one of the few initiatives in Australia which diverts people to mainstream mental health services on bail, where appropriate in this regard.

sampling was used to carry out data collection. The following findings addressing the study's four Research Questions relate to data gained from the focus group and interviews.

Research Question 1: *What are the health and cultural considerations of delivering holistic health care services for Aboriginal inmates in the ACT Alexander Maconochie Centre?*

Male and female respondent accounts recorded that problems with drugs and alcohol misuse are the underlying reason for their incarceration. Associated with their incarceration is a past history of stolen generations, dispossession, discrimination, issues about self-identification resulting in trauma and anger, mental health problems, lack of education and employment, family violence, bad health, poor diet, money issues, Police harassment, and poor diversional avenues. (Seven ex-prisoner respondents had been in children's homes in their youth). The majority of offences committed were theft, assault, breaking and entering or breaking parole. The average time of imprisonment was 6 months for those aged between 18-39 years. Of the 15 male ex-prisoners interviewed, 12 were in the 18-39 years age range. Recidivism was prevalent in both male and female respondents' histories. However, when approaching their fourth decade some ex-prisoners reach a stage when they want to become mentors.

Aboriginal people take poor health into prison, start from a much lower base than other prisoners, and do not cope well in prison. However, eating regular meals, exercising, receiving treatment for drugs and alcohol, and the support they receive from other Aboriginal inmates helps them to cope. The prison environment is not necessarily a place for rehabilitation because of prison drug culture, instances of self-harming and safety concerns (sexual abuse). Family visits, telephone conversations and letters are the major means of communication. Prisoners suffer extreme stress when a family death occurs. Depending on their classification they cannot always attend the funeral and require assistance in coping with the death.

There was a low rate of understanding of the term 'holistic care' amongst the study respondents. However, in the main, they expressed a preference for an Aboriginal prison medical service similar to the service delivered by Winnunga. This involves the physical wellbeing of the individual as well as the social, emotional and cultural wellbeing of the whole community, and includes the cyclical concept of 'life is health is life' (NAHSWP 1989: ix).

Research Question 2: *What are the specific health services required for holistic health care service delivery to Aboriginal inmates in the ACT Alexander Maconochie Centre?*

There was overwhelming concern amongst all the study respondents about contracting hepatitis C in prison, and bringing it into the community. Consequently in the main, respondents advocated for a prison needle and syringe program. They also nominated associated service requirements such as a fast response to methadone requirements on entering prison, drug and alcohol counseling, drug withdrawal rehabilitation treatment, testing for hepatitis B, C and HIV in the health assessment on entering prison, then every three months, and on release (with informed consent). Other health services considered essential were: optical and dental care, professional mental health treatment and counseling, and on-call primary health care. The respondents' perspectives about the lack of assistance for prisoners on release demonstrated the need for a prison case management plan developed on entry into prison. This would cover the prisoner's primary health care and social and emotional wellbeing needs in prison as well as post-release strategies as detailed in Recommendation 1 below.

The social and emotional wellbeing component of holistic care relates to prisoners' coping ability within the Corrective Services' culture. Consequently, fulfilling Aboriginal prisoners' cultural needs is paramount. This involves Corrective Services employing Aboriginal Correctional Officers and Aboriginal Liaison Officers. In addition, family contact and family days, contact with the wider Aboriginal community, access to spiritual healing programs, and cultural art, music, and sporting programs are also important. Training for employment, including numeracy and literacy programs and learning a trade contributes towards rehabilitation. Remandees have special concerns about preparing for court appearances. Participating in activities rather than in education courses may be more appropriate for remandees.

Research Question 3: *What are the health service implications for Winnunga?*

Winnunga currently provides health services to inmates at Goulburn and Cooma Prisons, and the Remand Centres in Belconnen and Symonston. These services will continue to be provided to the Goulburn and Cooma Prisons when the Alexander Maconochie Centre (AMC) opens in mid 2008. At this time inmates of the ACT Remand Centres will be relocated to the AMC. Winnunga's prison health responsibilities will then increase to also include

ACT prisoners sentenced in the ACT who are relocated from other prisons to the AMC. The study has developed the Winnunga Holistic Health Care Prison Model to provide services to the AMC - detailed in Recommendation 1.

This increased servicing will necessitate the development of a Winnunga Prison Health Service Team (PHST) (comprising male and female staff). The team will provide primary health care, and social and emotional wellbeing services to prisoners in the AMC, and to their families in the community. This holistic care will also be delivered to ex-prisoners and their families on release. Associated procedures will monitor and evaluate the model's implementation, operation, impact and outcomes. A coordination officer position within the Winnunga PHST will record details of the AMC as well as Goulburn Prison and Cooma Prison inmates and their families for inclusion in the Team's services. The stresses on families of prisoners and ex-prisoners are significant and necessitate increased social and emotional wellbeing outreach services. To avoid burnout through providing this holistic care, the welfare of the Winnunga PHST should be regularly monitored by the Winnunga Team Leaders. The Winnunga PHST should be rotated through other areas of Winnunga, rested, debriefed and counseled regularly.

Research Question 4: *Who are the other related organizations involved in providing these services and the communication requirements between these organizations?*

The other organizations involved in providing services to prisoners and ex-prisoners and families include: The Connection; Aboriginal Justice Centre; Gagan Gulwan Aboriginal Youth Corporation; CDEP or equivalent, such as the Shoalhaven Community Development Aboriginal Corporation; Aboriginal Legal Services; Circle Sentencing, Australian Federal Police Aboriginal Community Liaison; and other justice, health and community organizations currently accessed by Winnunga on behalf of clients. A formal network of support organizations relative to prisoners, ex-prisoners and family support requirements will be formed, formalized and maintained.

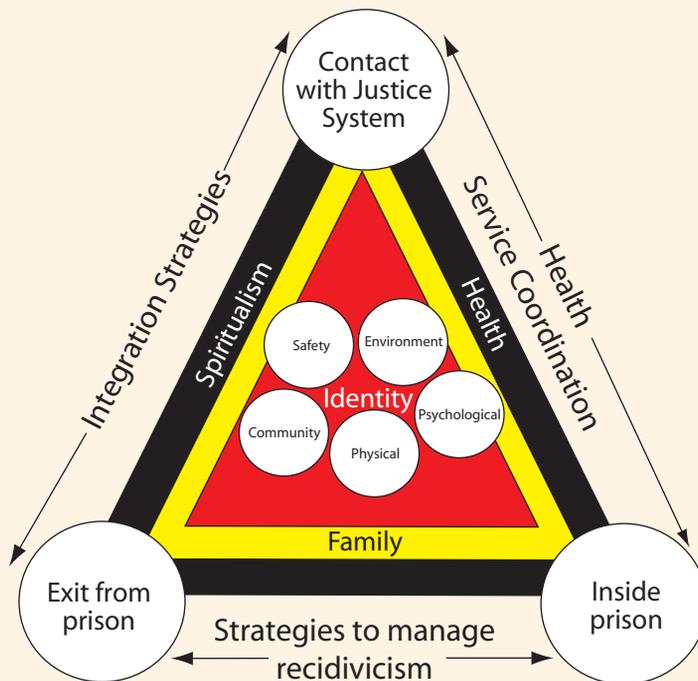
13.3 Study Recommendations

13.3.1 Recommendation 1

This study recommends the adoption of the Winnunga Holistic Health Care Prison Model (see Figure 13.3.2 below). The model addresses the needs

of prisoners and ex-prisoners and their families, and manages the cycle of incarceration. The model's premise is that post release needs should be addressed as a priority at reception into prison, and the focus of imprisonment is release into an environment which provides accommodation, employment, health services, and reintegration into the family and community. Winnunga is reliant on Corrective Services' advice about Aboriginal prisoners' entry and exit dates. The model reflects the first contact with the justice system. It takes into consideration the holistic care necessary for remandees and sentenced prisoners and their families (in prison and on release). The model also shows that family, health and spirituality are the three supporting components of those incarcerated and on release into the community. At the centre of the model is the need to develop a strong sense of identity which is crucial in coping with prison and community life. The ability to do this is dependent on the environment, safety, physical, psychological, and community support. Finally, health service coordination, and reintegration strategies into the community combine to manage the cycle of incarceration.

Figure 13.3.2 The Winnunga Holistic Health Care Prison Model.



Source: Arabena (2007).

The study recommends that the Winnunga Holistic Health Care Prison Model be delivered by the Winnunga Prison Health Service Team (PHST), (based at Winnunga). Increased staffing resources are required to deliver the Winnunga Holistic Health Care Prison Model to the AMC comprising:

- 1 x Coordination Officer – full time.
- 1 x Doctor – consultation once a week.
- 1 x Psychiatrist – consultation once a week.
- 1 x Dentist – twice a month service.
- 1 x Dental Assistant – twice a month service.
- 1 x Aboriginal Mental Health Worker – visits three times a week.
- 1 x Aboriginal Sexual Health Worker – visits three times a week.
- 1 x Aboriginal Drug and Alcohol Worker – visits three times a week.
- 1 x Aboriginal Maternal Health Worker – as required.

The male and female Aboriginal Health Workers would also provide advocacy and outreach to the community, and coordinate and communicate with the other health, community and justice organizations in the network providing services to prisoners, ex-prisoners, and their families. A significant feature of the Winnunga model is that it provides holistic care to prisoners and their families while incarcerated and on release. The proposed PHST staffing level allows for the rotation of team members, and resting, debriefing and counseling sessions to avoid burnout in an intimidating and difficult work situation.

At the individual prisoner level the Winnunga model is based on planning for release into a positive environment, at the time of entry into prison. It provides throughcare for remandees and sentenced persons. It concentrates on developing a sense of identity in prison through spirituality, changing drug culture activities that have resulted in incarceration for a positive and healthy life course, and recognising the strength of family and community in helping the cycle of incarceration. The study recommends that the Winnunga Holistic Health Care Prison Model for Aboriginal inmates be incorporated into the ACT Health prison services delivered at the AMC. The model has three parts:

- **Part 1: Incarceration** – provides holistic care during incarceration and planning for release.

- **Part 2: *Release from Prison*** — provides post-release health service coordination, and family and community reintegration strategies.
- **Part 3: *Managing the Cycle of Incarceration*** – provides early family, and other intervention strategies.

13.3.3 Part 1: Incarceration – Winnunga Holistic Health Care Prison Model

Identity

Identifying as an Aboriginal person is difficult for young people, as they are often unable to learn this culture from their parents. The consequences are that the struggle over identity, together with cultural dispossession, is manifested in pessimism, defeatism, poor self image and an inability to find a sense of belonging and acceptance (Beresford & Omaji 1996: 127). The premise of the ‘Identity’ component of the model is that a prisoner’s sense of identity can be developed and nurtured in a prison environment taking into consideration that the impact of the sentence can be positive through pre-release planning, the important components of which are provision of accommodation and reintegration into the family and community, promoting good health and social and emotional wellbeing through community outreach, and employment opportunities. This involves developing strategies around Aboriginal prisoners’ sense of spirituality (taking account of cultural and rehabilitation programs), prison environment and safety issues, physical and psychological support, and family and community support as follows.

Spiritual/Cultural Needs in Prison

The spiritual/cultural needs of Aboriginal prisoners involve access to the Marumali Healing Program, Ngangkari Spiritual Healing, listener training, Link-Up services, Elder support in prison and on release, Aboriginal history/colonization/acknowledgement of country and ancestors, peer education, Aboriginal life coaching/thinking about the future, prison transitional accommodation and work release into the community, 12 step programs (relating to eating, drugs, sex, alcohol, smoking), and a range of physical activities (e.g. guitar, yoga, music, cultural art, boxing, sport, gardening, meditation). Throughcare while in prison includes programs relating to health promotion, adult education, literacy and numeracy, vocational education and training including hospitality, welding and spray painting, and driving licence training. Throughcare also involves providing assistance in obtaining identification and Centrelink payments, future accommodation and

employment arrangements, and in keeping parole commitments. This will require a Cultural Awareness Training package to be developed for Corrective Services' staff, and a Memorandum of Understanding (MOU) so that access to these programs is not at the discretion of individual Corrective Services Officers.

Winnunga Actions: Provide and coordinate Aboriginal Health Workers and Community Elders and mentors for advocacy, and program coordination. Provide liaison and brokerage through the Muuji Regional Centre for Social and Emotional Wellbeing.

Prison Primary Health Care

Aboriginal prisoner health needs include culturally sensitive health programs that target early detection of chronic diseases and health promotion activities in prison. This means specific programs for physical and social and emotional wellbeing; primary care for diabetes; heart disease and other circulatory system disease; respiratory system disease; women's health including sexual health; maternal and child health; mental health and alcohol and drug issues.

Based on public health principles and human rights, and the European experience in six countries (Lines et al. 2004) introduce a prison needle and syringe program as part of a harm reduction philosophy to also include:

- Routine voluntary testing (with informed consent) for hepatitis B (and immunization where relevant), hepatitis C, and HIV on entry to and exit from the Alexander Maconochie Centre;
- Appropriate counseling;
- Distribution of condoms/dental dams;
- Provision of bleach or other disinfectants;
- Substitution therapy; and
- Treatment and care for HIV/AIDS, hepatitis and tuberculosis, and antiretroviral therapy.

The prison needle and syringe program accords with the ACT Health Minister's advice on 18 November 2005, that a needle exchange trial would be considered for the new ACT Prison.

Based on the Canadian Correctional Services' initiative, introduce a pilot program to train inmates to provide safe tattoos to prisoners, with strict controls on the tattoo equipment so that it stays within the prison tattoo parlour. Also conduct a trial air brushing tattoo program.

Winnunga Actions: Provide and coordinate Winnunga Youths at Risk Program (air brush tattooing), Winnunga Medical Practitioners and Aboriginal Health Workers for health promotion.

Prison Environment and Safety

Separation and Isolation

- Personally imposed – involves peer counselors;
- Institutionally imposed – involves advocacy policies to change system (e.g. Aboriginal Prisoners' Advocacy Group); and
- Family imposed – involves family hostel accommodation, and transport and finance to support families visiting relatives, funds for telephone calls from inmates to families, and family withdrawal rehabilitation facilities at the proposed ACT Bush Farm.

Safety

- Involves a buddy system, dispute resolution, and protective behaviours.

Winnunga Actions: Provide and coordinate Winnunga Health Workers for advocacy and prison and family liaison.

Psychological Effects of Prison

Transgenerational Trauma alleviated by:

- Parenting Programs - involves healing, spirituality and skills enhancement;
- Anger Management, Grief and Childhood Trauma Programs - involves group work, counseling, and mentoring;
- Sexual and Domestic Violence Management Program - involves counseling, and restorative justice;
- An Indigenous space to be used on a needs-based access to include prisoners' artwork and design of large murals guided by Winnunga

Youths at Risk Program and teachers. This would provide added interaction with the community; and

- Elders' Group and mentors – involves interaction with people who have experienced prison, drugs and alcohol misuse, sex offences, and is also a way of building self esteem, trusting relationships and throughcare on release.

Winnunga Actions: Provide and coordinate Aboriginal Health Workers and Community Elders and mentors for visits and delivering Programs including the Winnunga Youths at Risk Program.

Social Stresses/Trauma

First time/return prisoners – involves individual case management and coordination of services for resilience assessment, coping skills, psychological and psychiatric needs such as writing a diary/journal/sorry letter, and development of specific assessment tools. This also involves the development of a Corrective Services' Information Complaints Process Package for Aboriginal prisoners.

Winnunga Actions: Provide Winnunga Psychiatrist, Aboriginal Health Workers and Aboriginal Mental Health Workers.

Racism/Colonization

This requires Corrective Services developing policies for staff orientation and awareness about the Aboriginal culture and history, as well as cultural awareness training. This would involve penalties for ACT Corrective Services Officers who do not follow policy and a legitimate and formal complaints process for prisoners through the Ombudsman or tribunals.

Winnunga Actions: Provide Aboriginal Health Workers' advocacy.

Family and Community Support

This requires a Memorandum of Understanding (MOU) around family access and family days, and is not at the discretion of individual ACT Corrective Services Officers. Other support mechanisms are:

- Family access to Winnunga Prison Health Service Team;
- Advocacy assistance for prison visits including low cost accommodation;
- Policy on conjugal visiting rooms;
- ACT Corrective Services' observance of RCIADIC recommendations on deaths in custody (RCIADIC 1991);
- Funeral and burial support;
- Winnunga outreach work such as carers' support, home visits, school visits, medical health checks, and assistance with financial, educational, social, and relocation (for dysfunctional and at risk families) matters; and
- Production and supply of a Winnunga prison health information brochure.

Winnunga Actions: Provide a prison health information brochure. Provide and coordinate Aboriginal Health Workers' advocacy and outreach. Provide PHST Coordination Officer to establish and maintain a prisoner and family data base, and to strengthen the coordination of existing services.

13.3.4 Part 2: Release from Prison – Winnunga Holistic Health Care Prison Model

Identity

A sense of identity and belonging in the community on release is dependent on the success of the pre-release throughcare strategies (e.g. assistance with accommodation, employment, access to health services, identification papers, Centrelink payments, and parole commitments) developed on entry into prison. Similar to needs while in prison, integration into the family and community on release is dependent on spiritual/cultural needs, community primary health care, community environment and safety, psychological health, and family and community support.

Spiritual/Cultural Needs on Release

The spiritual/cultural needs of Aboriginal prisoners on release involve access to the following:

- Marumali Healing Program, and Ngangkari Spiritual Healing;
- the proposed Aboriginal Bush Farm (withdrawal rehabilitation facilities for families);
- the Aboriginal Cultural Centre on Yarrmundi Reach (under development);
- Boomanulla Sporting programs;
- Gugan Gulwan Aboriginal Youth Corporation's programs;
- Winnunga's mentoring programs through the Maintenance Program and Winnunga Youths at Risk Program – a combination of personal development and work ready skills including cultural art and music, boxing gym, mechanics' workshop and supervised work experience; and
- Winnunga Women's Gathering Support Group, Life Skills Program (including cooking), Positive Parenting Program, and Black Chicks Netball.

Winnunga Actions: Provide and coordinate Winnunga Programs, Aboriginal Health Workers' advocacy and outreach.

Community Primary Health Care

Aboriginal ex-prisoner health needs include follow-up action for health conditions identified in prison. The Winnunga Healthy for Life initiative takes a whole of life approach to reduce the incidence of adult chronic disease through prevention and early detection of diseases, and to enhance the quality of life of people with a chronic disease. Other areas of assistance include mental health, alcohol and drug withdrawal rehabilitation, and access to programs which improve the health of mothers, babies and children.

Winnunga Actions: Provide and coordinate Winnunga Medical Practitioners, and Aboriginal Health Workers.

Community Environment and Safety

This involves the following:

- employment;
- accommodation;
- health services;
- assistance with parole obligations;
- assistance if taken into custody, and assistance with court appearances; and
- minimizing the incidence of suicide after release.

Winnunga Actions: Provide and coordinate Aboriginal Health Workers' advocacy and outreach.

Psychological Health

Transgenerational Trauma is alleviated by the following:

- Positive Parenting Program – involves healing, spirituality and skills enhancement;
- Anger Management, Grief and Childhood Trauma Programs – involves group work, counseling, and mentoring;
- Sexual and Domestic Violence Management Program – involves counseling;
- Elders' Group and mentors – involves interaction with people who have experienced prison, drugs and alcohol misuse, and sex offences, and is also a way of building self-esteem and trusting relationships.

Winnunga Actions: Provide and coordinate Winnunga Programs and outreach with Aboriginal Health Workers, and Community Elders and mentors.

Social Stresses/Trauma

This takes into account the after effects of prison life such as feelings of shame and stigma in the community and involves assistance in developing coping and resilience skills.

Winnunga Actions: Provide and coordinate Winnunga Medical Practitioners, Aboriginal Health Workers, Community Elders and mentors.

Racism /Colonisation

This involves identifying racism within the wider community, for example, in places of employment, in schools, support organizations, and the Police and justice systems.

Winnunga Actions: Provide and coordinate Aboriginal Health Workers' advocacy.

Family and Community Support

The current lack of assistance to prisoners on release necessitates communication between the prison, external health care agencies and Aboriginal Health Services. This involves developing good organizational relationships and systematic discharge planning by the ACT Corrective Services health service providers. The recommended Winnunga Holistic Health Care Prison Model ensures that Winnunga, through the Aboriginal Health Workers, Community Elders and mentors, has continuity of involvement commencing with pre-release plans (developed on entry), thus ensuring that practical community assistance is coordinated through various support organizations.

This support commences at the prison gates on release with transport and access to nominated accommodation (i.e. return to the family home if appropriate, a short stay hostel, or assisted living in units or houses depending on the identified needs). Other practical needs are assistance with meeting parole commitments (i.e. keeping appointments, attending mental health or drug and alcohol withdrawal rehabilitation, men's and women's groups, parenting groups, Winnunga primary health care and social and emotional programs), Centrelink commitments, or starting a new job or job training.

In summary, on release ex-prisoners require housing and help during the following twelve months through outreach and advocacy assistance to keep parole and other commitments while they are adapting to life in the community. The proposed accommodation would be classified for high or

low level outreach and could also offer homeless people opportunities to remain in this accommodation. This would curtail domestic violence and increase the opportunity to maintain commitments detailed above. Assistance in re-housing ACT families who have relocated to NSW to be closer to their relatives in NSW prisons will be required.

Winnunga Actions: Provide and coordinate Aboriginal Health Workers' outreach and advocacy work. Coordinate Aboriginal Health Workers, Community Elders and mentors' communication with the network of support organizations.

13.3.5 Part 3: Managing the Cycle of Incarceration – Winnunga Holistic Health Care Prison Model

Identity

Culture and identity are central to Aboriginal perceptions of health and ill-health. How Aboriginal people view wellness and illness is in part based on cultural beliefs and values. At the health service interface these perceptions and the associated social interaction influence when and why Aboriginal communities access services, their acceptance or rejection of treatment, the likelihood of compliance and follow-up, the likely success of prevention and health promotion strategies, and their assessment of the quality of care.

Stressors such as substance, emotional and physical abuse, poor school attendance, low levels of education, high unemployment with poor job prospects, difficulties finding accommodation, lack of parental involvement or control, poverty, and being young single parents with poor parenting skills, are the problems facing young Aboriginal people (HRSCATSIA 2001: 40-92). These stressors exist:

- where mainstream culture is dominant;
- when establishing their identity as Aboriginal people, whilst balancing their involvement in the Aboriginal and mainstream community; and
- in facing the challenges for young people coming to terms with who they are. Aboriginal youth are an apocalyptic generation who do not envisage a future; having a sizeable minority with no apparent social norms, and a deep-seated hostility to white society (HRSCATSIA 2001: 74).

Spiritual/Cultural Needs

This is about healing (for example, participating in the Marumali Healing Program or the Ngangkari Spiritual Healing), empowerment and building resilience. Setting goals, having role models and a good education, putting Aboriginality first, knowing the positives and how to attain them, and believing it is possible to attain one's wishes, all contribute to a resilient life. Developing skills to obtain a Driving Licence helps assist in obtaining and attending work, and develops self-esteem. Playing sport assists in building support networks, self-esteem and respect.

Winnunga Actions: Provide and coordinate Winnunga Programs. Liaise with Boomanulla Oval, Gugan Gulwan, the Australian Federal Police, and other support organizations.

Community Primary Health Care

This involves participating in Winnunga's Healthy for Life initiative which takes a whole of life approach to reduce the incidence of adult chronic disease through prevention and early detection of diseases. Community primary health care enhances the quality of life of people with a chronic disease, and mental health and alcohol and drug problems. It also involves improving the health of mothers, babies and children.

Winnunga Actions: Provide and coordinate Medical Practitioners, Aboriginal Health Workers and Midwifery Team.

Community Environment and Safety

This involves the following:

- the need for diversionary measures from the criminal justice system for those with mental health problems, and treating substance abuse as a health issue as opposed to a law-enforcement matter. A model for this is the NSW service which diverts people to mainstream mental health on bail where appropriate (Greenberg & Nielsen 2002).
- early intervention with Aboriginal women in redressing their lack of education and employment opportunities, and providing treatment for sexual and physical abuse.

- encouraging parental support, good school attendance and school retention rates, and increasing access to Aboriginal education officers and Aboriginal school teachers.
- access to Parents' Groups, Men's and Women's Groups, Uncles/Nephews Programs, and Life Skills Programs (including cooking) can assist in maintaining families and family values.

Winnunga Actions: Provide and coordinate Medical Practitioners, Winnunga Programs, and Aboriginal Health Workers' advocacy.

Psychological Health

Transgenerational Trauma

This involves programs which reverse the effects of harsh government policies of the past about segregation and stolen children which have affected Aboriginal people and have translated into feelings of distrust, shame, shyness, and experiences of prejudice. The provision of parenting programs for both partners can encourage attachment to and a sense of responsibility for children. Children from 0-5 years of age need the grounding of good parenting to learn about discipline and self-esteem. In addition, the proposed Winnunga sport and recreation based program for drug users will encourage self esteem and general wellbeing. These programs assist in reducing juvenile detention which can lead to prison incarceration.

Winnunga Actions: Provide and coordinate Winnunga Programs.

Social Stresses/Trauma

This involves psychiatric/psychologist mental health assistance and counseling in developing coping/resilience skills.

Winnunga Actions: Provide and coordinate Winnunga Medical Practitioners and Aboriginal Health Workers.

Racism /Colonization

This involves identifying racism within the wider community, for example in places of employment, in schools, in support organizations, the Australian Federal Police, and the justice system. Cultural awareness training can help in these instances together with increased access to Aboriginal teachers and Aboriginal education officers.

Winnunga Actions: Provide and coordinate Aboriginal Health Workers' advocacy. Provide liaison and brokerage through the Muuji Regional Centre for Social and Emotional Wellbeing.

Family and Community Support

This involves the programs detailed in Part 2 of the Model and the Winnunga Youths at Risk Program which currently has five to ten participants a year. The participants are youth at risk or are recommended through court orders. They carry out course work in one or a combination of activities, in their own time. At the same time Winnunga supports and improves the participants' family environment – socially and emotionally. This program promotes self esteem and confidence, and automotive, cultural art, boxing and music skills, while maintaining a good family infrastructure. Winnunga's ongoing contact with the motor industry assists in obtaining their employment after training. Literacy and numeracy skills and obtaining a driving licence could also be developed in this type of learning environment.

Winnunga Actions: Provide and coordinate Winnunga Programs and Aboriginal Health Workers' outreach.

13.3.6. Recommendation 2 – Communication Strategies

This study recommends that a communication network be established between Winnunga and other Aboriginal and non-Aboriginal organizations detailed below. This is essential for primary health care delivery as well as social and emotional wellbeing of prisoners, ex-prisoners and their families.

SCATSIH (2005a) recommended that the prison risk assessment and management processes for self-harming behaviour (coming into custody, throughout prison life and on release), should incorporate partnership arrangements between the health and correctional authorities with appropriate sharing of information between jurisdictions. Consequently, this study recommends that Winnunga Aboriginal Health Workers formalize a communication process with the ACT Corrective Services including Aboriginal Liaison Officers, the ACT Health prison health staff of the Alexander Maconochie Centre, and other support organizations. For example, in the area of mental health, ACT Mental Health has given consideration to Winnunga Aboriginal Mental Health Workers being present during sessions between ACT Mental Health professionals and Aboriginal prisoners. Other partnerships with Winnunga, which accord with Recommendation 1, include The Connection, the Aboriginal Justice Centre, Gugan Gulwan Aboriginal Youth Corporation, CDEP, Shoalhaven Community Development Aboriginal Corporation, Aboriginal Legal Services, Circle Sentencing, Australian Federal Police Aboriginal Community Liaison, Boomanulla Oval, and relevant justice, health and community support organizations. Individual needs will vary in the extent to which people access the services of these support organizations.

13.3.7 Recommendation 3 – Monitoring and Evaluating the Winnunga Holistic Health Care Prison Model

This study recommends:

- implementation and monitoring the Winnunga Holistic Health Care Prison Model in the Alexander Maconochie Centre. This should be followed by process evaluation, impact evaluation and outcome evaluation of the model; and
- implementation and monitoring the communication network to include Winnunga and other Aboriginal and non-Aboriginal organizations detailed above. This should be followed by process evaluation, impact evaluation and outcome evaluation of the communication network.

13.3.8 Recommendation 4 – CRCAH Transfer of Knowledge and Understanding

This study recommends that the CRCAH transfer this new knowledge and understanding to the health and justice systems in other jurisdictions throughout Australia.

13.3.9 Recommendation 5 - Future Research

This study recommends that several important studies be undertaken to help overcome the current lack of an evidence base for Aboriginal prison-related health issues in the ACT and Australia more broadly. A significant finding of the Winnunga prison health research study has been the glaring lack of information in the published literature, both nationally and internationally, about Indigenous peoples, and more specifically Australian Aboriginal peoples, about prisons, prison health, and effective interventions to improve health outcomes, employ preventive health strategies, and manage the cycle of incarceration. The studies are:

- establishing a longitudinal study of Aboriginal people incarcerated in the Alexander Maconochie Centre, commencing with the opening of the facility in mid 2008, and involving Winnunga with selected research partners;
- establishing a cross-sectional study of juvenile justice and Aboriginal people prior to the opening of the Mitchell Juvenile Justice Centre in mid 2008;
- establishing a study into effective preventative programs for youth that might reduce the number of offenders;
- establishing a cross-sectional study of Aboriginal health in Police custody; and
- establishing an evaluation/review on the efficacy of current sentencing options given the disproportionate Aboriginal incarceration rates.

13.4 Implications for ACT Government of Winnunga Study Recommendations

The implications of the Winnunga prison health study for the ACT Government are:

- allocating funding for Winnunga Nimmityjah Aboriginal Health Service to deliver the Winnunga Holistic Health Care Prison Model;

- allocating funding for a community-based hostel and units or houses for Aboriginal ex-prisoners and their families, and families visiting relatives in prison;
- allocating funding for the Aboriginal-run Canberra Bush Farm residential treatment centre for Aboriginal drug users and their families;
- allocating funding for a bus service to visit relatives in Cooma and Goulburn Prisons, and the Alexander Maconochie Centre;
- authorizing an MOU for guaranteed access by Aboriginal inmates to Education and Rehabilitation Prison Programs;
- authorizing an MOU for guaranteed family access visits and family days to the Alexander Maconochie Centre (AMC);
- authorizing Cultural Awareness Training for Corrective Services staff of the AMC;
- authorizing Cultural Awareness Training for Australian Federal Police Officers;
- establishing a Complaints Process for Aboriginal prisoners of the AMC;
- establishing an Aboriginal Prisoners' Advocacy Group;
- authorizing routine voluntary testing (with informed consent) for hepatitis B (and immunisation where relevant), hepatitis C and HIV on entry to and exit from the AMC;
- establishing a needle and syringe program within the AMC; and
- authorizing increased Aboriginal teachers and Aboriginal education officers in ACT schools.

13.5 Implications for Commonwealth Government of Winnunga Study Recommendations

The implications of the Winnunga prison health study for the Commonwealth Government are:

- assuming the role of setting mandatory national standards for best practice in health service delivery in all prisons;
- specifying that Health Departments rather than Corrections deliver health services through Australia;
- allowing persons incarcerated by States and Territories access to the Pharmaceutical Benefit Scheme (PBS). Entitlements under the PBS and the Commonwealth Health Care Card should not change because of incarceration; and

- reinstating prisoners' federal election voting rights rescinded with the introduction of the Electoral and Referendum Amendment (Electoral Integrity and Other Measures) Act 2006.

BIBLIOGRAPHY

- AASW (Australian Association of Social Workers). (1999). *AASW Code of Ethics for Ethical Research in Indigenous Studies*. AASW. ACT.
- ABC (Australian Broadcasting Commission). (2003). *Aboriginal ngangkari heal the way*. Available at: <http://www.abc.net.au/central/stories/s1010419.htm>. [Accessed 15 March 2007].
- ABS (Australian Bureau of Statistics). (2002). *Population Distribution, Indigenous Australians, 2001*. Catalogue 4705.0. ABS. Canberra.
- ABS (Australian Bureau of Statistics). (2004). *Prisoners in Australia*. Catalogue 4517.O. ABS. Canberra.
- ABS (Australian Bureau of Statistics). (2005). *Prisoners in Australia*. Catalogue 4517.0. ABS. Canberra.
- ABS (Australian Bureau of Statistics). (2006). *Corrective Services, Australia, March 2006*. Catalogue 4512.0. ABS. Canberra.
- ABS & AIHW (Australian Bureau of Statistics and Australian Institute of Health and Welfare). (2005). *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2005*. Catalogue 4704.0. ABS. Canberra.
- ACTG (Australian Capital Territory Government). (2004). *Human Rights Act 2004*. ACT Parliamentary Counsel. Canberra.
- ACTG (Australian Capital Territory Government). (2006a). *Discussion Paper. The Review of the ACT Mental Health (Treatment and Care) Act 1994*. Mental Health Policy Unit. Canberra.
- ACTG (Australian Capital Territory Government). (2006b). *Draft ACT Corrections Health Service Plan 2006-2009*. ACTG. Canberra.
- AGDHFS (Australian Government Department of Health and Family Services). (1997). *National Drug Strategy. National Policy on Methadone Treatment*. AGDHFS. Canberra.

AHC (Australian Hepatitis Council). (2005). *First for Australia – needle exchange program for ACT prison*. Media Release. AHC. Canberra.

AHMAC (Australian Health Ministers' Advisory Council). (2004). *A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009*. Australian Government Department of Health and Ageing. Canberra.

AIATSIS (Australian Institute of Aboriginal and Torres Strait Islander Studies). (2002). *Guidelines for Ethical Research in Indigenous Studies*. AIATSIS. Canberra. Available at: http://www.aiatsis.gov.au/_data/assets/pdf_file/2290/ethics_guidelines.pdf [Accessed 20 April 2007].

AIC (Australian Institute of Criminology). (2006). *Illicit Drugs and Alcohol. Australian responses to illicit drugs: Drug courts*. Available at: http://www.aic.gov.au/research/drugs/responses/drug_courts.html. [Accessed 23 May 2007].

AIHW (Australian Institute of Health and Welfare). (2006). *Australia's health 2006. The tenth biennial health report of the Australian Institute of Health and Welfare*. Available at: <http://www.aihw.gov.au/publications/aus/ah06/ah06.pdf> [Accessed 7 May 2007].

ALRC (Australian Law Reform Commission). (1988). *Report 44 Sentencing. Special categories of offenders*. Available at: http://www.austlii.edu.au/cgi-bin/disp.pl/au/other/alrc/publications/reports/44/Ch_07. [Accessed 5 July 2006].

AMA (Australian Medical Association). (1998). *Health Care of Prisoners and Detainees. AMA Position Statement*. AMA. Barton ACT.

AMA (Australian Medical Association). (2006). *Undue Punishment? Aboriginal People and Torres Strait Islanders in Prison: An Unacceptable Reality*. AMA Report Card Series 2006. AMA. Barton ACT.

Anonymous. (2006). 'Health care in prisons and the health of prisoners UK'. *Medical News Today*. Available at: <http://www.medicalnewstoday.com/medicalnews.php?newsid=10907>. [Accessed 19 June 2006].

Anonymous. (2007). 'Axed prison tattoo program too short to prove worth'. *The Hep C Review* (March Edition 56), p 6. Available at: <http://www.hepatitisc.org.au/resources/documents/5601.pdf> [Accessed 20 April 2007].

Arabena, K. (2007). *Winnunga Holistic Health Care Prison Model*. Winnunga Prison Health Workshop, 23 February 2007. Canberra.

Atkinson, J. (2002). *Trauma Trails, Recreating Song Lines. The Transgenerational Effects of Trauma in Indigenous Australia*. Spinifex. North Melbourne.

Bailey, S. (2003). *Native Women Suffer Most in "Discriminatory" Prison System: Advocates*. Available: <http://dawn.thot.net/fsw2.html>. [Accessed 23 March 2006].

Barry, J. (1967). 'Maconochie, Alexander (1787-1860)'. *Australian Dictionary of Biography*, vol 2: 185-186. Melbourne University Press. Melbourne.

Baum, F., MacDougall, C. & Smith, D. (2006). 'Participatory action research'. *Journal of Epidemiol Community Health*, vol 60: 854-857.

Beauchamp, T. & Childress, J. (2001). *Principles of Biomedical Ethics* (5th Ed). Oxford University Press. Oxford.

Behrendt, L. (2006). *National Indigenous Times* (November, 16) p 18.

Bellamy, E. (2006). 'Up Where They Belong'. (November 29). *The Canberra Times*, p 1.

Beresford, Q. & Omaji, P. (1996). *Rites of Passage. Aboriginal Youth, Crime and Justice*. Fremantle Arts Centre Press. Western Australia.

- Brinded, P., Simpson, A., Laidlaw, T., Fairley, N. & Malcolm, F. (2001). 'Prevalence of psychiatric disorders in New Zealand prisons: a national study'. *Australian and New Zealand Journal of Psychiatry*, vol 35: 166-173.
- Brooke, D., Taylor, C., Gunn, J. & Maden, A. (1996). 'Point prevalence of mental disorder in unconvicted male prisoners in England and Wales'. *British Medical Journal*, vol 313: 1524-1527.
- Brown, P. & Butler, T. (1997). *Inmate Health Survey*. NSW Corrections Health Service. Sydney.
- Butler, T., Dolan, K., Ferson, M., McGuinness, L., Brown, P. & Robertson, P. (1997). 'Hepatitis B and C in New South Wales prisons: prevalence and risk factors'. *Medical Journal of Australia*, vol 166: 127-130.
- Butler, T. & Milner, L. (2003). *The 2001 New South Wales Inmate Health Survey*. NSW Corrections Health Service. Sydney. Available at: http://www.justicehealth.nsw.gov.au/pubs/Inmate_Health_Survey_2001.pdf [Accessed 20 April 2007].
- Butler, T. & Allnutt, S. (2003). *Mental Illness Among New South Wales Prisoners*. NSW Corrections Health Service. Matraville NSW. Available at: http://www.justicehealth.nsw.gov.au/pubs/Mental_Illness_Among_NSW_Prisoners_2003.pdf [Accessed 20 April 2007].
- Butler, T., Boonwaat, L., Hailstone, S., Falconer, T., Lems, P., Ginley, T., Read, V., Smith, N., Levy, M., Dore, G. & Kaldor J. (2007). 'The 2004 Australian prison entrants' blood-borne virus and risk behaviour survey'. *Australian and New Zealand Journal of Public Health*, vol 31, no 1: p 44-50.
- CAAN (The Canadian Aboriginal AIDS Network). (2004). *HIV/AIDS and Aboriginal Women, Children and Families. A Position Statement*. CAAN. Ottawa, Canada.

- Canadian HIV/AIDS Legal Network. (2004). *HIV/AIDS in Prisons 2004/2005, Aboriginal Prisoners and HIV/AIDS*. Canadian HIV/AIDS Information Centre.
- Carcach, C., Grant, A. & Conroy, R. (1999). *Australian Corrections: The Imprisonment of Indigenous People*. Australian Institute of Criminology Trends & Issues. Canberra.
- Clear, T. & Cadora, E. (2003). *Community Justice*. Thomson Wadsworth. Florence, Kentucky.
- Corbell, S. (2006). *Bovis Lend Lease to Build Alexander Maconochie Centre*. Media Release (October, 16). ACT Government. Canberra.
- Crofts, N., Stewart, T., Hearne, P., Ping, X., Breskin, A. & Lorcarnini, S. (1995). 'Spread of blood-borne viruses among Australian prison entrants'. *British Medical Journal*, vol 310: 285-288.
- Crofts, N., Thompson, S., Wale, E. & Hernberger, F. (1996). 'Risk behaviours for blood-borne viruses in a Victorian prison'. *Australian and New Zealand Journal of Criminology*, vol 29: 20-28.
- CSC (Correctional Service Canada). (1989). *The Task Force on Federally Sentenced Women*. Available at: http://www.csc-cc.gc.ca/text/prgrm/correctional/abissues/challenge/11_e.shtml. [Accessed 29 November 2006].
- CSC (Correctional Service Canada). (2005). *Section II: Analysis of Program Activities by Strategic Outcome*. Available at: http://www.tbs-ct.gc.ca/est-pre/20052006/csc-scc/csc-sccr5602_e.asp. [Accessed 29 November 2006].
- CSC (Correctional Service Canada). (2006). *Aboriginal federal offender surveys: a synopsis*. Available at: http://www.csc-scc.gc.ca/text/pblct/forum/e121/e121h_e.shtml. [Accessed 10 July 2006].
- Cunneen, C. (2002). *NSW Aboriginal Justice Plan Discussion Paper*. Aboriginal Justice Advisory Council. Sydney, NSW.

- Davidson, J. (2004). *Inside outcasts: prisoners and the right to vote in Australia*. Current Issues Brief No 12 2003-04. Parliamentary Library, Commonwealth of Australia. Canberra.
- Day, C. & Dolan, K. (2001). *Characteristics of Indigenous Injecting Drug Users in Sydney: Gender, Prison History and Treatment Experiences*. Paper presented at the Australian Institute of Criminology, Best Practice Interventions in Corrections for Indigenous People Conference, Sydney 8-9 October 2001.
- Desmond, R. (2007). 'Coroner calls for clean jail syringes'. (January 19). *News.com.au*. Available at: <http://www.news.com.au/story/0,23599,21085820-1702,00.html>. [Accessed 23 January 2007].
- Dolan, K., Hall, W. & Wodak, A. (1994). *Bleach Availability and Risk Behaviours in Prison in New South Wales*. Technical Report No 22. National Drug and Alcohol Research Centre. Sydney.
- Dolan, K., Wodak, A. & Hall, W. (1998). 'Methadone maintenance treatment reduces heroin injection in NSW prisons'. *Drug and Alcohol Review*, vol 17: 153-158.
- Dolan, K. & Rouen, D. (2003). 'Evaluation of an Educational Comic on Harm Reduction for Prison Inmates in New South Wales'. *International Journal of Forensic Psychology*, vol 1, (1), p 138-141.
- Dukes, C., Malone, T., Millbank, A., Victoria, J. & Henderson, G. (2004). *Aboriginal and Torres Strait Islander social and emotional wellbeing and what we can do to improve it: Muuji Regional Centre for Social and Emotional Wellbeing*. Poster presentation, 18th World Conference, International Union for Health Promotion and Education. Melbourne.
- Eade, D. (1997). *Capacity-Building: An Approach to People-Centred Development*. Oxfam Publishing. Oxford.
- Foucault, M. (1975). *Discipline and Punish: The birth of the Prison*. Translated by Alan Sheridan (1977). Pantheon Books. New York.

- Foucault, M. (1980). *Power/Knowledge: Selected Interviews and other Writings*. Colin Gordon (Ed). Pantheon Books. New York.
- Freudenberger, H. (1974). 'Staff burn-out'. *Journal of Social Issues*, vol 30: 159-165.
- Glaser, B. & Strauss, A. (1967). *Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine. Chicago.
- Gore, S., Bird, A., Burns, S., Goldberg, D., Ross, J. & Macgregor, J. (1995). 'Drug injection and HIV prevalence in inmates of Glenochil prison'. *British Medical Journal*, vol 310: 293-296.
- Gorta A. (1992). *Monitoring the NSW Prison Methadone Program: A Review of Research 1986-1991*. Research Publication 25. NSW Department of Corrective Services. Sydney.
- Green, S. & Baldry, E. (2006). *Building Indigenous Australian Social Work Theory and Practice*. Paper presented at the Indigenous Social Work Conference, June 2006. Australian Catholic University. Canberra
- Greenberg, D. & Nielsen, B. (2002). 'Court Diversion in NSW for People With Mental Health Problems and Disorders'. *NSW Public Health Bulletin*, vol 13, no 7: 158-160.
- Guba, E. & Lincoln, Y. (1989). *Fourth Generation Evaluation*. Sage, Newbury Park. California.
- Gunn, J., Maden, A. & Swinton, M. (1991). 'Treatment needs of inmates with psychiatric disorders'. *British Medical Journal*, vol 303: 338-341.
- Guthrie, J., Butler, T. & Sefton, A. (2003). 'Measuring health service satisfaction: female inmates'. *International Journal of Health Care Quality Assurance*, vol 16, no 4: 173-179.

Hazlehurst, K. & Dunn, A. (1988). *Aboriginal criminal justice*. Australian Institute of Criminology Trends & Issues in crime and criminal justice No 13. Canberra.

HM Prison Service. (2006). 'Prison Mental Health Transfer Project'. *Prison Health Newsletter*, Issue 21, Spring 2006: 5.

HREOC (Human Rights and Equal Opportunity Commission). (1997). *Bringing Them Home. A Report of the National Inquiry into Separation of Aboriginal and Torres Strait Islander Children from Their Families*. HREOC. Sydney.

HREOC (Human Rights and Equal Opportunity Commission). (2002). Aboriginal & Torres Strait Islander Social Justice Commissioner. *Social Justice Report 2002*. HREOC. Sydney.

HREOC (Human Rights and Equal Opportunity Commission). (2003). Aboriginal & Torres Strait Islander Social Justice Commissioner. *Submission to the Expert seminar on Indigenous Peoples and the administration of justice, Madrid, Spain*. Available: http://www.hreoc.gov.au/social_justice/madrid/issue2.html. [Accessed 15 December 2006].

HREOC (Human Rights and Equal Opportunity Commission). (2005). Aboriginal & Torres Strait Islander Social Justice Commissioner *Social Justice Report 2005*. Available at: http://www.humanrights.gov.au/social_justice/sjreport05/index.html [Accessed 15 June 2006].

HRSCATSIA (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs). (2001). *We can do it! The needs of urban dwelling Aboriginal and Torres Strait Islander Peoples*. Parliament of the Commonwealth of Australia. Canberra.

Hunter, P. (1999). 'Searching for a New Way of Thinking In Aboriginal Health'. *The Australian Health Consumer*, vol 2: 16-17.

Hunter, B. (2001). *Indigenous Australian arrest rates: Economic and social factors underlying the incidence and number of arrests*. CAEPR, ANU. Canberra. (CAEPR Working Paper No 10/2001).

Johnson, H. (2004). *Drugs and Crime: A Study of Incarcerated Female Offenders*. Australian Institute of Criminology. Canberra.

Joudo, J. (2006). *Deaths in custody in Australia 1990-2004. No 309*. Australian Institute of Criminology. Canberra.

Kassen, M. (1999). *Aboriginal Healing Programs. An Administrative Perspective*. Paper presented at the Best Practice Interventions in Corrections for Indigenous People Conference, 13-15 October 1999. Adelaide.

Kilroy D. (2004). *Submission of Sisters Inside to the Anti-Discrimination Commissioner for the Inquiry into the Discrimination on the Basis of Sex, Race and Disability Experienced by Women Prisoners in Queensland*. Sisters Inside. South Brisbane.

Krieg, A. (2006). 'Aboriginal incarceration: health and social impacts'. *Medical Journal of Australia*, vol 184, no 10: 534-536.

Kunitz, S. (2002). 'Holism and the idea of general susceptibility to disease'. *International Journal of Epidemiology*, vol 31: 722-729.

Lawrie, R. (2002). *Speak out speak strong: researching the needs of Aboriginal women in custody*. Aboriginal Justice Advisory Council. Sydney.

Levy, M. (1999). *Partnerships for Indigenous Health*. Paper presented at the Best Practice Interventions in Corrections for Indigenous People Conference, 13-15 October 1999. Adelaide.

Levy, M. (2002). 'Prisoners' Right to Health and Safety'. In Brown, D. & Wilkie, M. (Ed). *Prisoners as Citizens. Human Rights in Australian Prisons*. (p 240-256). The Federation Press. Annandale, NSW.

- Levy, M. (2005). 'Prisoner health care provision: Reflections from Australia'. *International Journal of Prisoner Health*, vol 1, no 1: 65-73.
- Levy, M. (2007). Personal Communication, February 2007.
- Lewis, G & Slade, C. (2000). *Critical Communication* (2nd Ed.) Prentice Hall. Frenchs Forest NSW.
- Lines, R., Jurgens, R., Betteridge, G., Stover, H., Laticevschi, D. & Nelles, J. (2004). *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*. Canadian HIV/AIDS Legal Network.
- Lunt, P. & Livingstone, S. (1996). 'Rethinking the Focus Group in Media and Communications Research'. *Journal of Communication*, vol 46 (2), p 79-98.
- Lutschini, M. (2005). *Engaging with holism in Australian Aboriginal health policy – a review*. Available at: <http://www.anzhealthpolicy.com/content/2/1/15>. [Accessed 11 October 2006].
- McClelland, G., Teplin, L., Abram, K. & Jacobs, N. (2002). 'HIV and AIDS Risk Behaviors Among Female Jail Detainees: Implications for Public Health Policy'. *American Journal of Public Health*, vol 92, no 5: 818-825.
- McDougall, L. (2007). 'Explosive report reveals true extent of prison drug abuse epidemic'. *The Hep C Review*, Edition 56: 30-31.
- McGaha, S. (2000). *Michel Foucault. Theorist Web Project*. Available at: <http://www.criminology.fsu.edu/crimtheory/foucault.htm>. [Accessed 5 June 2006].
- Miller, K., Birkholt, M., Scott, C. & Stage, C. (1995). 'Empathy and burnout in human service work: An extension of a communication model'. *Communication Research*, vol 22: 123-147.

- Miller K. (1999). *Organizational Communication. Approaches and Processes*. (2nd Ed). Wadsworth Publishing Company. Belmont, California.
- Muuji (Muuji Regional Centre for Social and Emotional Wellbeing). (undated). *Muuji Brochure*. Muuji. Canberra.
- NAHSWP (National Aboriginal Health Strategy Working Party). (1989). *A National Aboriginal Health Strategy*. Department of Aboriginal Affairs. Canberra.
- NATSIHC (National Aboriginal and Torres Strait Islander Health Council). (2003a). *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for Action by Governments*. NATSIHC. Canberra.
- NATSIHC (National Aboriginal and Torres Strait Islander Health Council). (2003b). *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Context*. NATSIHC. Canberra.
- Neill, R. (2002). *White Out. How politics is killing black Australia*. Allen & Unwin. Crows Nest, NSW.
- NHMRC (National Health and Medical Research Council). (2003). *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. NHMRC. Canberra. Available at: http://www.nhmrc.gov.au/ethics/human/conduct/guidelines/_files/e52.pdf [Accessed 20 April 2007].
- NHMRC (National Health and Medical Research Council). (2004). *The NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health Through Research*. NHMRC. Canberra. Available at: http://www.nhmrc.gov.au/publications/synopses/_files/r28.pdf [Accessed 20 April 2007].

NHMRC (National Health and Medical Research Council). (2006). *Keeping research on track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics*. NHMRC. Canberra. Available at: http://www.nhmrc.gov.au/publications/synopses/_files/e65.pdf [Accessed 20 April 2007].

NHMRC (National Health and Medical Research Council). (2007). *National Statement on Ethical Conduct in Research Involving Humans*. NHMRC. Canberra. Available at: http://www.nhmrc.gov.au/publications/synopses/_files/e72.pdf [Accessed 20 April 2007].

NSWAJAC (NSW Aboriginal Justice Advisory Council). (1999). *Policing Public Order, Offensive Language and Behaviour: The Impact on Aboriginal People*. NSWAJAC. Sydney.

NSWAJAC (NSW Aboriginal Justice Advisory Council). (2002). *Aboriginal People & Bail Courts in NSW*. NSWAJAC. Sydney.

NSWSCIPP (NSW Select Committee on the Increase in Prisoner Population). (2000). *Issues Relating to Women. Interim Report*. NSW Legislative Council. Sydney.

NZMOH (New Zealand Ministry of Health). (1995). *He Taura Tieke: Measuring effective health services for Maori*. NZMOH. Wellington.

OA & NACCHO (Oxfam Australia & National Aboriginal Community Controlled Health Organization). (2007). *Close the gap. Solutions to the Indigenous Health Crisis Facing Australia. A policy briefing paper from the National Aboriginal Community Controlled Health Organization and Oxfam Australia*. Oxfam. Fitzroy, Melbourne.

Ochberg, F. (1988). *Post-traumatic therapy and victims of violence*. Brunner/Mazel. New York.

Okasha, A. (2004). 'Mental patients in prisons: punishment versus treatment?' *World Psychiatry*, vol 3, no 1: 1-2.

- Open Society Institute & Soros Foundations Network. (2004). *New Report Shows Benefits of Prison Needle Exchange*. Available at: http://www.soros.org/initiatives/health/focus/ihrd/news/prisonnep_20041027. [Accessed 18 December 2006].
- Patton, M. (1990). *Qualitative Evaluation and Research Methods*. 2nd Ed. Sage Publications. Newbury Park, California.
- Pines, A. (1982). 'Changing organizations: Is a work environment without burnout an impossible goal?' In Paine, W. (Ed). *Job stress and burnout: Research, theory and intervention perspectives* (p 172-191). Sage. Newbury Park, California.
- Post, J., Dolan, K., Whybin, L., Carter, I., Haber, P. & Lloyd, A. (2001). 'Acute hepatitis C virus infection in an Australian prison inmate: Tattooing as a possible transmission route'. *Medical Journal of Australia*, vol 174: 183-184.
- Prisonjustice.ca. (2003). *Prisons Are a Failed Experiment Especially for Women*. Available at: http://www.prisonjustice.ca/politics/1012_failedexp.html. [Accessed 13 June 2006].
- Prisonjustice.ca. (2004). *Correctional Investigator Calls for Needle Exchange in Prisons. Ombudsman calls for inmate needle exchange*. Available at: http://www.prisonjustice.ca/starkravenarticles/CI_call_needle_exchange_1104.html. [Accessed 17 July 2006].
- Prisonjustice.ca. (2005a). *Safe Tattooing Trial Sites Set Up in Six Prisons. Prison program provides low-cost tattoos*. Available at: http://www.prisonjustice.ca/starkravenarticles/safetattooing_1105.html. [Accessed 17 July 2006].
- Prisonjustice.ca. (2005b). *Native Leaders Call for Alternatives to Jail for Women*. Available at: http://www.prisonjustice.ca/starkravenarticles/alternatives_mb_0605.html. [Accessed 13 June 2006].
- Queensland Government. (2006). *The Drug Court*. Available at <http://www.justice.qld.gov.au/courts/factsht/C10DrugCrt.htm> . [Accessed 18 May 2007].

RCIADIC (Royal Commission into Aboriginal Deaths in Custody). (1991). *National Report, vols. 1-5 and Overview and Recommendations*. Australian Government Publishing Service. Canberra.

RCIADIC (Royal Commission into Aboriginal Deaths in Custody). (1992). *Aboriginal Deaths in Custody. Overview of the Response by Governments to the Royal Commission*. Australian Government Publishing Service. Canberra.

Reconciliation and Social Justice Library. (1996). *National Report Deaths in Custody Index*. Available at: <http://www.auslii.edu.au/au/special/rsjproject/rsjlibrary/rciadic/national/vol3/141.html>. [Accessed 22 June 2006].

Robinson, J. (1994). *Prison HIV peer education: report of the National Prison HIV Peer Education Project*. Australian Institute of Criminology. Canberra.

Rutter, S., Dolan, K. & Wodak, A. (1996). *Sex, Drugs and Viruses in Sin City Sydney 1994*. National Drug and Alcohol Research Centre (NDARC) Technical Report No 37. NDARC. Sydney.

Rutter, S., Dolan, K., Wodak, A. & Heilpern, H. (2001). *Prison-Based Syringe Exchange Programs. A Review of International Research and Program Development*. National Drug and Alcohol Research Centre (NDARC). Sydney.

SCATSIH (Standing Committee on Aboriginal and Torres Strait Islander Health). (2005a). *Guidance on Operational Standards for the Provision of Health Services to Aboriginal and Torres Strait Islander People in Custody*. Australian Health Ministers Advisory Council (AHMAC). Canberra

SCATSIH (Standing Committee on Aboriginal and Torres Strait Islander Health). (2005b). *Policy Guidelines for the Provision of Health Services to Aboriginal and Torres Strait Islander People in Custody*. Australian Health Ministers Advisory Council (AHMAC). Canberra.

Sharma, K. (2005). *Indigenous Governance*. KPS Publications. Canberra.

Simpson, A., Brinded, P., Fairley, N., Laidlaw, T. & Malcolm, F. (2003). 'Does ethnicity affect need for mental health service among New Zealand prisoners?' *Australian and New Zealand Journal of Psychiatry*, vol 37: 728-737.

Sinclair, R. (2004). 'Aboriginal Social Work Education in Canada: Decolonizing Pedagogy for the Seventh Generation'. *First Peoples Child and Family Review*, vol 1 (1), p 49-61. Available at: http://www.fnccfs.com/pubs/vol1num1/Sinclair_pp49-61.pdf [Accessed 20 April 2007].

Smith, L. (1999). *Decolonizing Methodologies. Research and Indigenous Peoples*. University of Otago Press. Dunedin.

Snowball, L. & Weatherburn, D. (2006). 'Indigenous over-representation in prison: The role of offender characteristics'. *Contemporary Issues in Crime and Justice* 99 (September). NSW Bureau of Crime Statistics and Research. Sydney.

Stanhope, J. (2004a). *Green Light for ACT Prison*. Media Release, (January 9). ACT Government. Canberra.

Stanhope, J. (2004b). *Welcome to the ACT Prison Project Website*. Available at: <http://www.cs.act.gov.au/amc/home> [Accessed 31 January 2007].

Stewart, L., Henderson, C., Hobbs, M., Ridout, S. & Knuiman, M. (2004). 'Risk of death in prisoners after release from jail'. *Australian New Zealand Journal of Public Health*, vol 28: 32-36.

Stoeber, H. (2002). *Drug substitution treatment and needle exchange programs in German and European prisons*. Available at: http://www.findarticles.com/p/articles/mi_qa3733/is_200204/ai_n9059459/print. [Accessed 22 June 2006].

- Streak, D. 'Rate of black deaths slowing'. (2006, August 7). *The Canberra Times*, News 7.
- Streak, D. 'Many voices crying out to be heard'. (2007, January 22). *The Canberra Times*, p 10.
- Swan, P. & Raphael, B. (1995). 'Ways Forward'. *National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health, Part 1*. Australian Government Publishing Service (AGPS). Canberra.
- Sydney Morning Herald.com.au*. (2001, December 1). 'The view from inside'. Available at: <http://old.smh.com.au/news/0112/01/review/review5.html> [Accessed 13 September 2002].
- Taylor, S. (1994). *NSW Prison HIV Peer Education Program: An Evaluation*. Research Publication No 30. NSW Corrective Services. Sydney.
- Taylor, A., Goldberg, D., Emslie, J., Wrench, J., Gruer, L., Cameron, S., Black, J., Davis, B., McGregor, J., Follett, E., Harvey, J., Basson, J., & McGavigan, J. (1995). 'Outbreak of HIV infection in a Scottish prison'. *British Medical Journal*, vol 310: 289-292.
- The Canberra Times*. (2006). 'Treat drug abuse as health issue: expert'. (July 4), p 7.
- Thomas, D., Condon, J., Anderson, I., Li S., Halpin, S., Cunningham, J. & Guthridge, S. (2006). 'Long-term trends in Indigenous deaths from chronic diseases in the Northern Territory: a foot on the brake, a foot on the accelerator'. *The Medical Journal of Australia*, vol 185 (3): 145-149.
- Tomasevski, K. (1992). *Prison Health. International standards and national practices in Europe*. Publication Series No 21. Helsinki Institute for Crime Prevention and Control. Helsinki.
- UN (United Nations). (1955). *Standard Minimum Rules for the Treatment of Prisoners*. Available at: <http://www.ohchr.org/english/law/treatmentprisoners.htm>. [Accessed 6 October 2006].

- UNCESCR (United Nations Committee on Economic, Social and Cultural Rights). (2000). *General comment 14: The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*. UN Doc E/C.12/2000/4, 11 August 2000, para 1.
- UNHRC (United Nations Human Rights Council). (2006). *United Nations Declaration on the Rights of Indigenous Peoples*. Available at: <http://www.ohchs.org/english/issues/indigenous/docs/declaration.doc>. [Accessed 19 October 2006].
- USADJ (United States of America Department of Justice). (1999). *American Indians and Crime*. Available at: <http://www.ojp.usdoj.gov/bjs/pub/press/aic.pr>. [Accessed 9 March 2007].
- Wadsworth, Y. (2001). 'The Mirror, The Magnifying Glass, The Compass and the Map – Facilitating Participatory Action Research'. In Reason, P. & Bradbury, H. (Eds). *Handbook of Action Research*. Sage Publications. London p 420-439.
- Wallerstein, I. (2000). *The Essential Wallerstein*. Available at: <http://www.yale.edu/sociology/faculty/pages/wallerstein>. [Accessed 21 June 2006].
- Wenitong, M. & Daniels, J. (2003). 'Custodial Health'. In Couzos, S. & Murray, R. *Aboriginal Primary Health Care. An Evidence-based Approach*. (2nd Ed.). Oxford University Press. South Melbourne, p 608-616.
- WHO (World Health Organization). (2005a). *Status Paper on Prisons, Drugs and Harm Reduction*. WHO Regional Office for Europe. Denmark.
- WHO (World Health Organization). (2005b). *International Conference on Prison and Health Proceedings, 17 October 2005*. London.
- WHO (World Health Organization). (2007). WHO Regional Office in Europe. *Health in Prison Project*. Available at: <http://www.euro.who.int/prisons>. [Accessed 18.04.2007].

- Williams, P. (2001). *Deaths in Custody: 10 Years on from the Royal Commission. No 203*. Australian Institute of Criminology. Canberra.
- Wimmer, R. & Dominick, J. (1994). *Mass Media Research. An Introduction*. (4th Ed). Wadsworth Publishing. Belmont, California.
- Winnunga (Winnunga Nimmityjah Aboriginal Health Service). (2005). *Winnunga Nimmityjah Aboriginal Health Service Annual Report 2004-2005*. Winnunga. Available at: <http://www.winnunga.org.au/report.htm> [Accessed 11 November 2006].
- Winnunga (Winnunga Nimmityjah Aboriginal Health Service). (2006a). *Winnunga Nimmityjah Aboriginal Health Service Annual Report 2005-2006*. Winnunga. Canberra.
- Winnunga (Winnunga Nimmityjah Aboriginal Health Service). (2006b). *Agenda – Roundtable on Indigenous health and human rights*. Winnunga. Canberra.
- Winnunga (Winnunga Nimmityjah Aboriginal Health Service). (undated). Brochure. *Aboriginal health sector – the torchbearer of primary health care for over 30 years*. Winnunga. Canberra.
- Wynhausen, E. ‘Justice that looks beyond jail’. (2006, May 27). *The Australian*. Available at: <http://www.theaustralian.news.com.au/printpage/0,5942,19264849,00.html>. [Accessed 13 June 2006].
- Yap, L., Butler, T., Richters, J., Kirkwood, K., Grant, L., Saxby, M., Ropp, F. & Donovan, B. (2006). *Do condoms cause rape and mayhem? The long-term effects of condoms in New South Wales’ prisons. Abstract in Sexually Transmitted Infections*, Accepted for publication December 2006. Available at: <http://sti.bmj.com/cgi/content/abstract/sti.2006.022996v1>. [Accessed 28 March 2007].

TELEPHONE SURVEY

Representatives of Aboriginal Medical Services (AMSs). Personal communication, August 2006 – March 2007.

APPENDIX A INTERVIEWS EX-PRISONER AND FAMILY MEMBERS

APPENDIX A INTERVIEWS SUPPORT ORGANISATIONS

APPENDIX A – EX-PRISONER AND FAMILY INTERVIEWS

Category	No of Interviewees	Gender	Age
Aboriginal Ex-prisoners	15	M	2x18-25 9x26-35 2x36-45 2x46-55
Aboriginal Ex-prisoners	7	F	3x18-25 1x36-45 3x46-55
Aboriginal Prisoners' Families	5	M	2x18-25 3x26-35
Aboriginal Prisoners' Families	12	F	3x18-25 4x26-35 1x36-45 1x46-55 3x56-65
TOTAL	39		

(**Note:** one male family member interviewed was non-Aboriginal)

APPENDIX A – EX-PRISONER AND FAMILY INTERVIEWS

Male Ex-Prisoner Interviewees

	Interview Date
A	6 September 2006
B	23 August 2006
C	29 August 2006
D	1 September 2006
E	11 September 2006
F	8 September 2006
G	1 September 2006
H	1 September 2006
I	30 August 2006
J	1 September 2006
K	14 August 2006
L	14 August 2006
M	30 August 2006
N	8 September 2006
O	6 September 2006

Female Ex-Prisoner Interviewees

	Interview Date
P	14 August 2006
Q	14 August 2006
R	8 September 2006
S	8 September 2006
T	15 August 2006
U	14 September 2006
V	15 September 2006

Male Family Interviewees

	Interview Date
LL	14 August 2006
MM	11 September 2006
NN	1 September 2006
OO	14 September 2006

APPENDIX A – EX-PRISONER AND FAMILY INTERVIEWS

Female Family Interviewees	Interview Date
AA	25 August 2006
BB	7 September 2006
CC	8 September 2006
DD	11 September 2006
EE	14 August 2006
FF	29 August 2006
GG	11 September 2006
HH	15 August 2006
II	1 September 2006
JJ	8 September 2006

APPENDIX A – INTERVIEWS SUPPORT ORGANIZATIONS

Organization	Gender	Interview Date
Winnunga Nimmityjah AHS		
Health Worker – Interviewee 13 (N)	F	11 September 2006
Health Worker - Interviewee 29 (A)	M	9 November 2006
Health Worker – Interviewee 03 (A)	M	18 October 2006
Health Worker – Interviewee 06 (A)	F	14 November 2006
Health Worker – Interviewee 25 (A)	M	31 October 2006
Doctor – Interviewee 17 (N)	M	16/6 & 23/11 2006
Psychiatrist – Interviewee 23 (N)	F	21 November 2006
Health Worker/Project Officer - Interviewee 28 (A)	M	6 November 2006
Gugan Gulwan Aboriginal Youth Corporation		
Drug & Alcohol Worker – Interviewee 20 (A)	M	18 October 2006
Belconnen Remand Centre		
Doctor – Interviewee 16 (N)	M	13 September 2006
Nurse – Interviewee 09 (N)	F	1 October 2006
Liaison Officer – Interviewee 15 (A)	F	18 September 2006
ACT Corrective Services		
Parole Officer – Interviewee 12 (A)	F	4 October 2006
Manager, Indigenous Services – Interviewee 04 (A)	M	12 September 2006
Manager, Projects Senior Policy Officer – Interviewee 32 (N)	F	22 November 2006
ACT Health		
Senior Planning Officer (N)	M	3 July 2006
Prisoners' Aid		
Prison Visitor – Interviewee 26 (N)	M	11 July 2006
The Connection		
Coordinator – Interviewee 02 (A)	M	14 September 2006

Directions ACT

Aboriginal Support Counselor –
Interviewee 21 (N) F 20 October 2006

Aboriginal Justice Centre

Case Manager – Interviewee (A) M 29 November 2006

Circle Sentencing

Coordinator – Interviewee 24 (A) F 5 September 2006

Australian Hepatitis Council

Policy Officer – Interviewee 08 (A) M 10 October 2006

The Nannies' Group

(5 members) – Interviewees 05 (A) F 13 September 2006

Australian Federal Police

Aboriginal Community Liaison
Officer (Unsworn) – Interviewee 27 (A) M 16 October 2006

The Australian National University

Drug and Alcohol Researcher –
Interviewee 07 (N) M 23 October 2006

Mental Health ACT

Director – Interviewee 31 (N) F 31 October 2006

Program Manager (N) F 31 October 2006

Centrelink

Prison Liaison Officer - Interviewee 30 (N) F 24 October 2006

Prison Liaison Officer (N) F 24 October 2006

Marumali Healing Program

Program Manager – Interviewee 11 (A) F 15 October 2006

Support Organization Victoria

Port Philip Prison Health Worker –
Interviewee 10 (A) M 19 October 2006

NSW Health Services

Prisons Project Officer – Interviewee 10 (A) M 9 October 2006

Nunkuwarrin Yunti Aboriginal Medical Service, Adelaide

Doctor – Interviewee 22 (N) F 18 November 2006

Correctional Services, South Australia

Executive Officer – Interviewee 19 (A) F 17 November 2006

TOTAL **39**

(**Note:** A =Aboriginal; N = Non-Aboriginal)

APPENDIX B – THE DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLE RELATING TO ABORIGINAL PRISONERS (SELECTED ARTICLES)

Article 1: Indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration of Human Rights and international human rights law.

Article 2: Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their indigenous origin or identity.

Article 3: Indigenous peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

Article 4: Indigenous peoples in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions.

Article 5: Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their rights to participate fully, if they so choose, in the political, economic, social and cultural life of the State.

Article 6: Every indigenous individual has the right to a nationality.

Article 21: Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.

Article 21.2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.

APPENDIX B – THE DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLE RELATING TO ABORIGINAL PRISONERS (SELECTED ARTICLES)

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.

APPENDIX C – INTERVIEWS AND FOCUS GROUP QUESTIONS

- **BEST PRACTICE MODEL OF PRISON HEALTH – ACT ALEXANDER MACONOCHIE CENTRE – INTERVIEW EX-PRISONERS**
- **BEST PRACTICE MODEL OF PRISON HEALTH – ACT ALEXANDER MACONOCHIE CENTRE – INTERVIEW EX-PRISONERS’ FAMILIES**
- **BEST PRACTICE MODEL OF PRISON HEALTH – ACT ALEXANDER MACONOCHIE CENTRE – INTERVIEW/ FOCUS GROUP REPRESENTATIVES OF SUPPORT ORGANIZATIONS**

APPENDIX C – INTERVIEW QUESTIONS

BEST PRACTICE MODEL OF PRISON HEALTH – ACT ALEXANDER MACONOCHIE CENTRE – INTERVIEW EX-PRISONERS

Interviewer: _____ Co-Researcher: _____

Date of Interview: _____ Time Start _____ Finish: _____

Interviewee Name: _____

Male/Female _____

Age: 18-25; 26-35; 36-45; 46-55; 56-65; 66 plus _____

Length of Time in Prison: _____ Name of Prison: _____

How many times have you been in prison? _____ Names of Prisons: _____

Aboriginal or Torres Strait Islander: _____

Which mob do you belong to? _____

The Interview has five parts:

- Your own story of how you got to be in prison;
- How you looked after your health and wellbeing in prison;
- How your family got on while you were in prison;
- Any courses or health programs you did in prison or on release;
- Whether culture and tradition helped you with prison life.

We are looking at providing a holistic health service for Aboriginal and Torres Strait Islander prisoners in the new ACT Prison and your story will help us do this. People have many ideas of what a holistic health service which looks after health and wellbeing should be. Some of the ideas are a healthy lifestyle; healthy body; social and emotional health; cultural and spiritual health; economic circumstances; and where you live.

1. So can you tell us what good health and wellbeing means for you?
2. Can you tell us your own story of how you got to be in prison?

PART 1 – HEALTH CARE RECEIVED IN PRISON

- 1.How well did you cope overall with being in prison?
- 2.Thinking back on your time in prison how did you look after your own health?
- 3.What health services did you need when you were in prison?
- 4.Who were the best people who looked after your health?
Prompt on whether they were able to give all health care needed.
- 5.What part did Winnunga play in providing health services to you in prison?
- 6.Can you tell us about the state of your health going into prison and if your health changed while in prison?
- 7.Did prison Aboriginal Liaison Officers visit you while in prison?
Prompt on whether they helped or not.
- 8.Were there any education or rehabilitation programs that made a difference to your wellbeing in prison and afterwards?
- 9.How well did you cope with family crises while you were in prison?
- 10.Can you comment on cultural groups housed together in prison for health, wellbeing or safety?

SUB THEME – SERVICES NOT PROVIDED TO ABORIGINAL PRISONERS

- 1.Are there any important health and wellbeing services not provided to Aboriginal prisoners in prison?
- 2.How does this affect Aboriginal prisoners?

SUB THEME – DESIRED HEALTH SERVICES AND PROGRAMS IN THE NEW ACT PRISON

1. What sort of health services and programs for Aboriginal prisoners would you like to see in the new ACT Prison?
2. Which organizations could provide these services?

PART 2 – FAMILY WELFARE

1. How were the family visits when you were in prison?
Prompt on any problems with visiting.
2. Were there other ways you kept in touch with your family?
Prompt whether by phone or letters.
3. What difficulties did your family experience while you were in prison?
4. How did Winnunga or other organizations help your family when you were in prison?
5. How can this support be improved?

PART 3 – ORGANIZATIONS PROVIDING PROGRAMS ON RELEASE

1. What support did you get when you were released (i.e. work, accommodation, family support)?
2. What support did your family get when you were released?
Prompt on what they would have needed.
3. What has been your experience of settling back in the family and community since your release?
4. What sort of continuing support would help you and your family now you are out of prison (Aboriginal and non-Aboriginal support)?
5. Can you tell us about non-Aboriginal organizations in the community that

have helped you and your family on release?

6.What part has Winnunga played in helping you and your family on release?

7.How can support organizations help in keeping people out of prison?

PART 4 – CULTURE AND TRADITION IN PRISON

1.While you were in prison were there any courses on Indigenous culture available?

Prompt on whether they would have wanted this.

2.Were you able to receive visits from Elders or get the Koori Times, or any information about family?

Prompt on whether they would have wanted this.

3.Can you think of any cultural/religious/spiritual programs that prisons could run which might keep people out of prison?

Prompt on benefit of telling stories, and Aboriginal therapies.

ANY OTHER COMMENTS OR QUESTIONS

THANK YOU

**APPENDIX C – INTERVIEW QUESTIONS
BEST PRACTICE MODEL OF PRISON HEALTH – ACT ALEXANDER
MACONOCHE CENTRE – INTERVIEW EX-PRISONERS’
FAMILIES**

Interviewer: Co-Researcher:

Date of Interview: Time Start: Finish:

Interviewee Name:

Age of interviewee: 18-25; 26-35; 36-45; 46-55; 56-65; 66 plus

Male/Female

Relationship to prisoner:

Gender of relative in prison:

Aboriginal or Torres Strait Islander?

Which mob do you belong to?

Age of family member when they were in prison: 18-25; 26-35; 36-45; 46-55;
56-65; 66 plus

Is your family member in prison now? If not how long have they been out or
prison?

Length of time family member in prison:

How many times family member in prison? Names of prisons:

The interview has five parts:

Your own story of what it was like when your family member was in prison;
The type of health care they received in prison;
The type of support you received at this time;

Any courses or health programs they did in prison or when they were released;

Whether their culture and tradition helped them with prison life.

We are looking at providing a holistic health service for Aboriginal and Torres Strait Islander prisoners in the new ACT Prison and your story will help us to do this. People have many ideas of what a holistic health service which looks after health and wellbeing should be. Some of the ideas are a healthy lifestyle; healthy body; social and emotional health; cultural and spiritual health; economic circumstances and where you live.

1. So can you tell us what good health means for you?

2. Can you tell us how your family member got to be in prison?

3. Can you tell us what it was like for you when your family member was in prison?

PART 1 – HEALTH CARE OF FAMILY MEMBER IN PRISON

1. Looking back on your family member's time in prison how well did they cope overall with being in prison?

2. Can you comment on cultural groups housed together in prison for health, wellbeing or safety?

3. Do you know how they were able to look after their health in prison?
Prompt on type of medical services they needed.

4. Were they able to get all the health care they needed in prison?

5. What part did Winnunga play in providing health services to your family member in prison?

6. Did prison Aboriginal Liaison Officers visit your family member in prison?
Prompt on whether they helped or not.

7. What was the state of their health going into prison and has it changed while

in prison or when they were released?

8. Were there any education courses or rehabilitation programs that made a difference to their wellbeing in prison and when they were released?

SUB THEME – SERVICES NOT PROVIDED TO ABORIGINAL PRISONERS

1. Are there any important health and wellbeing services not provided to Aboriginal prisoners in prison?

2. How does this affect Aboriginal prisoners?

SUB THEME – HEALTH SERVICES AND PROGRAMS IN THE ACT PRISON

1. What sort of health services and programs for Aboriginal prisoners would you like to see in the new ACT Prison?

2. Which organizations could provide these services?

PART 2 – FAMILY WELFARE

1. How were the family visits when your family member was in prison?
Prompt on whether they received petrol money.

2. Were there other ways you kept in touch with your family member in prison?
Prompt - whether by phone or letter contact.

3. How did your family member cope with family crises while they were in prison?

4. What difficulties did you experience while your family member was in prison?

5. How did Winnunga or other organizations help you when your family member was in prison?

6.How can this support be improved?

PART 3 – ORGANIZATIONS PROVIDING PROGRAMS WHEN FAMILY MEMBER RELEASED

1.How has your family member settled back in the family and community since their release?

2.What support did your family member get when they were released ie. work, accommodation, family support?

3.What support did you get when your family member was released?
Prompt on what they would have needed.

4.What sort of continuing support would help the family when the family member is released (Aboriginal or non-Aboriginal support)?

5.Can you tell us about non-Aboriginal organizations in the community that have helped you and your family member on release?

6.What part has Winnunga played in helping you and your family on release?

7.How can support organizations help in keeping people out of prison?

PART 4 – CULTURE AND TRADITION IN PRISON

1.While your family member was in prison were there any courses on Aboriginal culture available?
Prompt on whether they would have wanted this.

2.Were they able to receive visits from community members/Elders in prison?
Prompt on whether they would have wanted this.

3. What sort of information such as community news and news of important cultural events were they able to get in prison?

4.Can you think of any cultural/religious/spiritual programs that prisons could

run which might keep people out of prison?
Prompt on benefit of telling stories, and Aboriginal therapies.

ANY OTHER COMMENTS OR QUESTIONS

THANK YOU

APPENDIX C – INTERVIEWS AND FOCUS GROUP QUESTIONS

BEST PRACTICE MODEL OF PRISON HEALTH – ACT ALEXANDER MACONOCHIE CENTRE - INTERVIEW/FOCUS GROUP - REPRESENTATIVES OF SUPPORT ORGANIZATIONS

Interviewer:

Date of Interview:

Interviewee Name:

Name of Support Organization:

Occupation:

Male/Female

Age: 18-25; 26-35; 36-45; 46-55; 56-65; 66 plus

Aboriginal or Torres Strait Islander?

Which mob do you belong to?

The Interview has five parts:

- The services you provide for Aboriginal prisoners and on release
- The health care they receive in prison
- Welfare of the family of prisoners
- Support on release for ex-prisoners and their families
- The role of culture and tradition

We are looking at providing a holistic health service for Aboriginal and Torres Strait Islander prisoners in the new ACT Prison and your comments will help us do this.

The idea of holistic health includes a healthy lifestyle, healthy body, social and emotional health, cultural and spiritual health, and economic circumstances.

Can you tell me about your role at Winnunga/in your organization?

Can you tell me how you help Aboriginal prisoners and on release?

Can you me how you help families of Aboriginal prisoners in prison and on release?

PART 1 – HEALTH CARE RECEIVED IN PRISON

1. Can you comment on how most Aboriginal people get to be in prison?

2. How well do they cope overall with being in prison?

3. How good are they at looking after their health in prison?

4. What are the health services generally accessed by Aboriginal people in prison?

5. What is their attitude to Aboriginal/non-Aboriginal organizations providing health care in prison?

6. What is the state of their health going into prison and on release?

7. Can you comment on the benefits or not of Aboriginal Liaison Officers assisting Aboriginal people in prison?

8. Can you comment on the benefits or not of education courses or rehabilitation programs in prison?

9. Can you comment on cultural groups housed together in prison?

10. How well do Aboriginal inmates cope with family crises while in prison?

11. What connection with Winnunga do you currently have in supporting Aboriginal prisoners?

12. What is the method of communication between your organization and Winnunga in supporting prisoners?

13. How can this support be improved?

SUB THEME – SERVICES NOT PROVIDED TO ABORIGINAL PRISONERS

1. Are there any important health and wellbeing services not provided to Aboriginal prisoners?
2. How does this affect Aboriginal prisoners?

SUB THEME – DESIRED HEALTH SERVICES AND PROGRAMS IN THE NEW ACT PRISON

1. What sort of health services and programs for Aboriginal prisoners would you like to see in the new ACT Prison?
2. Which organizations could provide these services?
3. What are the communication links which should be put in place for these services?
4. What involvement will your organization have in providing support to prisoners in the new ACT Prison?

PART 2 – FAMILY WELFARE

1. What difficulties do families of prisoners experience while a family member is in prison?
2. In what way is your organization able to support families of Aboriginal prisoners?
3. What connection with Winnunga do you currently have in supporting Aboriginal prisoners' families?
4. How can the support/communication links be improved?

PART 3 – SUPPORT PROGRAMS ON RELEASE

1. What type of support does your organization provide to ex-prisoners on release?
2. What type of continuing support does your organization provide to ex-prisoners and their families?
3. What connection with Winnunga do you currently have in supporting Aboriginal prisoners and their families on release?
4. How can the support/communication links be improved?
5. How can support organizations better assist ex-prisoners to settle back into the family and community?
6. How can support organization assist in keeping people out of prison?

PART 4 – CULTURE AND TRADITION

1. To what extent does knowledge of Aboriginal culture and tradition assist Aboriginal prisoners in prison and on release?
2. Can you think of any cultural/religions/spiritual programs in prison and in the community which might keep people out of prison?
Prompt on benefit of telling stories and Aboriginal therapies.

PART 5 – THE STRESS OF HOLISTIC CARE WORK.

1. Can you tell me how you de-stress from the issues you encounter in your work?

ANY OTHER COMMENTS OR QUESTIONS

THANK YOU

APPENDIX D - PARTICIPANT CONSENT FORM

APPENDIX E - RESEARCH STUDY INFORMATION SHEET

APPENDIX E - RESEARCH STUDY INFORMATION SHEET

Health Care Model for Aboriginal and Torres Strait Islander Inmates of the New ACT Alexander Maconochie Centre

We invite you to participate in the research study into a health care model for Aboriginal and Torres Strait Islander inmates of the new ACT Alexander Maconochie Centre.

What is the research about?

Winnunga Nimmityjah Aboriginal Health Service and Muuji Regional Centre for Social and Emotional Wellbeing, in partnership with the Australian Institute of Aboriginal and Torres Strait Islander Studies; the National Centre for Indigenous Studies at The Australian National University; and Healthpact Research Centre for Health Promotion and Wellbeing at the University of Canberra are conducting focus group and individual interviews with ex-inmates and their families.

These focus groups and interviews will collect information for the best culturally appropriate holistic health care service for inmates and their families while in the ACT Centre and when they are released.

Why are we doing this research?

The purpose of the research study is to collect data to help to develop a model of holistic health service delivery for Aboriginal and Torres Strait Islander inmates of the new ACT Centre and in other Centres throughout Australia.

What will I be asked about?

The research team will ask about:

- Holistic health services for Aboriginal prisoners and on release
- The health care they receive in prison
- Welfare of the family of prisoners
- Support on release for ex-prisoners and their families
- The role of culture and tradition in keeping Aboriginal people out of prison

Who is the Research Team?

The research team includes Indigenous and non-Indigenous researchers from Winnunga Nimmityjah AHS and The Connection – A Safe Place for Indigenous Youth.

Confidentiality

All members of the research team are required to sign a confidentiality agreement prohibiting them from discussing the information you provide any time before, during or after the research study is finished.

What will happen to the information I provide?

The things that we will produce from these interviews are:

1. A report on your stories about health care in prison will be produced and given back to your community as a draft for discussion and approval. Once the community has made changes a final report will be produced and given back to the community.
2. A final report will be produced for the ACT Chief Minister incorporating information from the interviews and focus groups. This report will advise the Chief Minister for the ACT of the best culturally appropriate holistic health care service for inmates of the new ACT Alexander Maconochie Centre.

Will I be personally identified?

If you agree to participate in the research we will record what you tell us. All information provided during focus groups or interviews will be reported in a general way. People will not be individually identified or named without written permission. Only the research team will have access to the information. All information collected for this study will be stored in a secure place and will be destroyed when the report is finished.

How will the draft reports be fed back to the community and to people who participated in the research?

Members of the research team will return to the community once a draft has been written to present the findings of the report to a community meeting. Focus group participants will have the opportunity to discuss the draft report and suggest changes.

How will I be able to clear the reports before publication?

If you provided an in-depth interview we will ensure that you have the opportunity to clear your material before publication.

Who can I contact

For further information about this research study you can contact Jodie Fisher at Winnunga Nimmityjah AHS, Telephone 02 62846214 and Nerelle Poroch at Winnunga Nimmityjah AHS, Telephone 02 62846260.

If you have any concerns or questions about how this research is being carried out, you can contact Chrissy Grant, Chairperson, Research Ethics Committee, Australian Institute of Aboriginal and Torres Strait Islander Studies, Lawson Crescent, Acton ACT 2601, Telephone 02 6261 4221.

