



2015

AMA REPORT CARD ON INDIGENOUS HEALTH

Treating the high rates of imprisonment of
Aboriginal and Torres Strait Islander peoples
as a symptom of the health gap:
an integrated approach to both



CLOSING THE GAP ON INDIGENOUS IMPRISONMENT RATES

The AMA Indigenous Health Report Card series commenced in 2002 with an overview of the health of Aboriginal and Torres Strait Islander peoples, which was aptly titled **'No More Excuses'**.

In the ensuing years, the AMA Report Cards have covered important issues such as the Indigenous medical workforce, low birth weight babies, institutionalised inequity, childhood health, the health of Indigenous males, the inadequacy of funding, best practice in primary care, and getting the right start in life in the early years.

The Report Cards have contributed to the broader debate around progress, or lack of it, in Indigenous health, and have been catalysts for informed further discussion.

We like to think that they have all brought about some changes – in thinking, in action, in policy, and results. But we also know that some issues crawl along with little change, and maybe go backwards.

In 2006, the AMA first cast its spotlight on the circumstances of Indigenous incarceration and the links to the lifetime health conditions of Aboriginal and Torres Strait Islander people who have spent time in prison.

Aboriginal and Torres Strait Islander peoples' imprisonment rates are rising dramatically. There was a 10 per cent increase from 8430 prisoners in 2013 to 9264 at 30 June 2014.



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Disturbingly, Aboriginal and Torres Strait Islander 10 to 17 year olds are 17 times more likely as non-Indigenous young Australians to have been under youth justice supervision. In health terms, this can be a life sentence.

This Report Card is full of similar chilling statistics and the horrific effects being in prison can have on the health of individuals, and how these health issues can stay with these people throughout their lives.

But this Report Card is about more than defining the problem – it is about prescribing solutions.

The AMA commends this Report Card to everybody involved with and concerned about Indigenous incarceration and its effect on the health of Aboriginal and Torres Strait Islander people.

Above all, we urge our political leaders at all levels of government to take note of this Report Card and be motivated to act to implement solutions. No more excuses.

A handwritten signature in black ink, appearing to read 'B. Owler'.

Professor Brian Owler

President, Australian Medical Association
November 2015

EXECUTIVE SUMMARY

Among the divides between Aboriginal and Torres Strait Islander peoples and non-Indigenous people in Australia, the health and life expectancy gap and the stark difference in the rates of imprisonment are among the most well-known.

- It is estimated that, on average, an Indigenous male born in 2010-2012 will live just over 10 years less than their non-Indigenous peers (69.1 and 79.7 years respectively) and an Indigenous female just under 10 years less than her non-Indigenous peers (73.7 and 83.1 years respectively).¹ Life expectancy is a proxy indicator for overall health and wellbeing. Each year, the Prime Minister, reports against 'Closing the Gap' targets that include one to close the life expectancy gap by 2030.²
- The age standardised imprisonment rate for Aboriginal and Torres Strait Islander peoples was 13 times greater than for their non-Indigenous peers in 2015.³ The year 2016 marks a grim milestone in the numbers of Aboriginal and Torres Strait Islander peoples being held in custody. At the end of the 2015 June quarter, the average daily number of Aboriginal and Torres Strait Islander adult prisoners was 9940, comprising 8938 males and 1002 females.⁴ Under current projections, for the first time over 10,000 Indigenous people could be in custody on the night of the annual prison census on 30 June 2016. At the 2015 June quarter, Aboriginal and Torres Strait Islander people represented 28 per cent of all adult full-time prisoners⁴ despite being only three per cent of the population.⁵ They accounted for approximately two per cent of the total Aboriginal and Torres Strait Islander population.⁴

This Report Card treats the two gaps as connected. While acknowledging the complex drivers of imprisonment in any individual's case, it considers the 'imprisonment gap' as symptomatic of the health gap. In particular, the AMA believes it is possible to isolate particular health issues (mental health conditions, alcohol and other drug use, substance abuse disorders, and cognitive disabilities are the focus of this report card) as among the most significant drivers of the imprisonment of Aboriginal and Torres Strait Islander peoples, and target them as health issues as a part of an integrated approach to also reduce imprisonment rates.

Further, this Report Card examines how the situation is compounded by a health system and prison health system that, despite significant improvements over past decades, remains - in many critical areas - unable to respond appropriately to the needs of Aboriginal and Torres Strait Islander prisoners.

The year 2016 marks two anniversaries that make this Report Card timely.

- The first is the 25th anniversary of the report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). As this Report Card demonstrates, many of its recommendations are as relevant today as they were in 1991.
- The second is the 10th anniversary of the 2006 AMA Indigenous Health Report Card, *Undue Punishment? Aboriginal and Torres Strait Islander People in Prison: An Unacceptable Reality*.⁶ At that time, Aboriginal and Torres Strait Islander peoples comprised 22 per cent of the prison population, and an Indigenous person was 12 times more likely to be in prison than a non-Indigenous peer.⁶ As the 2015 data above demonstrates, today the situation is worse.



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The AMA's 2006 Indigenous Health Report Card called on the Australian Government to 'keep out of prison those who should not be there, principally those with mental health and substance abuse disorders'⁶ by: setting targets to reduce imprisonment among this cohort; screening all those on remand and following sentencing for mental health problems within 48 hours; and diverting them to best practice treatment and support programs.⁶

This Report Card builds on these calls by recommending:

- setting a national target for 'closing the gap' in the rates of imprisonment of Aboriginal and Torres Strait Islander peoples (that is, bringing it down to at least the rates among non-Indigenous people); and
- adopting a justice reinvestment approach to fund services that will divert individuals from prison as a major focus.

Our 2006 Report Card on Indigenous Health also called on the Australian Government to 'ensure that health services provision in prisons is the best it can be, in particular supporting inmates to take control of their health and the determinants of their health.'⁶

This Report Card builds on this call by recommending that Australian governments adopt an integrated approach to reducing imprisonment rates and improving health through much closer integration of Aboriginal Community Controlled Health Organisations (ACCHOs), other services and prison health services across the pre-custodial, custodial and post-custodial cycle. Key elements of this approach are:

- a focus on health issues associated with increased risk of contact with the criminal justice system and imprisonment. In particular, mental health conditions, alcohol and drug use, substance abuse disorders and cognitive disabilities;
- service models that incorporate both health care and diversionary practices. These models would be developed by ACCHOs working in partnership with Australian governments and prison health services. Such would define the roles, and integrate the work of, ACCHOs, other services and prison health services to provide the integrated approach;
- preventing criminalisation and recidivism. The former, by detecting individuals with health issues that can put them at risk of imprisonment while in the community and working with them to treat those issues and prevent potential offending; and
- continuity of care. That is, (a) from community to prison - with a particular focus on successfully managing release. And (b) post-release (from prison to community) - with a focus on successful reintegration of a former prisoner into the community and avoiding recidivism. Important elements of continuity of care include access to health records, and individual case management as available.

A critical part of the implementation of this approach is likely to involve:

- expanding the capacity of ACCHOs and other services as required to establish and/or build on existing interdisciplinary mental health and social and emotional wellbeing teams that can work effectively with or coordinate health care for people at risk of imprisonment while in the community and work to divert them from potential contact with the criminal justice system;



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- ensuring that these interdisciplinary mental health and social and emotional wellbeing teams are connected to, or include, culturally competent professionals to work effectively with mental health disorders, substance abuse disorders, and cognitive disabilities; and
- supporting prison health services to be able to deliver a culturally safe and competent service including by employing greater numbers of Aboriginal Health Workers and Indigenous health professionals, and working in partnership with ACCHOs or other services.

Because Aboriginal and Torres Strait Islander peoples tend to come into contact with the criminal justice system at younger ages than their non-Indigenous peers, a major focus of this integrated approach is on the health, wellbeing, and diversion from the criminal justice system of Aboriginal and Torres Strait Islander children and adolescents. Culturally-based approaches have been identified as effective in working with this cohort in areas like suicide prevention.⁷ The AMA anticipates that the integrated approach it is recommending would incorporate access to Elders and cultural healers as a core component.

The recommendations in this Report Card further develop the AMA's 2012 *Position Statement on the Health and Criminal Justice System*⁸ that stated:

- Aboriginal and Torres Strait Islander peoples should 'have full access in prison to culturally safe primary health care, including management of chronic illness, social and emotional wellbeing, mental health, and drug and alcohol problems';
- Aboriginal and Torres Strait Islander cultures are 'respected in the design and provision of health and medical care in prisons and juvenile detention facilities'; and
- Aboriginal and Torres Strait Islander prisoners have access ... 'to community elders and to relevant representatives of their communities to address their cultural beliefs and needs'.⁸

They also complement the AMA's 2014 *Alcohol Summit Communiqué*, which recommended that a national alcohol strategy be developed, and that this should include strategic responses to increase availability of targeted alcohol prevention and treatment services throughout the community; and include measures that specifically respond to the particular needs and preferences of Aboriginal and Torres Strait Islander people.⁹

It is the AMA's hope that this Report Card will help build momentum for a national integrated approach to reducing both the Aboriginal and Torres Strait Islander health and imprisonment gaps - one that understands both as aspects of each other. Such an approach is aligned with the integrated, whole of life, and holistic approaches that Aboriginal and Torres Strait Islander peoples have long called for as responses to both.¹⁰

It is not credible to suggest that Australia, one of the world's wealthiest nations, cannot solve a health and justice crisis affecting three per cent of its citizens.¹¹ The high rates of health problems among, and the imprisonment of, Aboriginal and Torres Strait Islander peoples should be a priority social justice and human rights issue in this context.

Recommendations

- 1** Set a national target for closing the gap in the rates of Aboriginal and Torres Strait Islander imprisonment.
- 2** Adopt a justice reinvestment approach to fund services that will divert Aboriginal and Torres Strait Islander people from prison.
- 3** Develop service models to support the expansion of ACCHOs and other services as part of an integrated approach to improving the health of Aboriginal and Torres Strait Islander peoples in the community (including responding to mental health conditions, substance use disorders and cognitive disabilities based on need) and as a preventative measure to reduce imprisonment rates.
- 4** In partnership with ACCHOs, prison health services, and other services as appropriate, develop a model of health care that integrates ACCHOs, prison health services, and other services to deliver an integrated approach to service provision that aims to improve health and reduce imprisonment rates at the same time.
- 5** Employ Aboriginal Health Workers and Indigenous health professionals in prison health services to support them to deliver a culturally competent health service.

PART 1

THE HIGH RATES OF IMPRISONMENT OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES AND THE CONNECTION TO HEALTH ISSUES

Understanding why Aboriginal and Torres Strait Islander peoples experience both poorer health and higher rates of imprisonment when compared to non-Indigenous people must include an acknowledgement of the political and social context of their situation.

To start, the impacts of the historical determinants associated with colonisation (such as child removals and reduced access to country) can leave individuals, families, and communities vulnerable to mental and physical health and wellbeing problems¹², and high rates of imprisonment. Today, these manifest as social determinants that include social exclusion, unemployment, lower access to quality education, poverty,¹³ lack of political power, and racism.¹⁴

Associated with these are high rates of stressful life events that can cause psychological distress, trauma, mental health conditions and disorders, and contribute to at-risk alcohol and other drug use and substance use disorders.¹⁵ Yet, despite the higher reported rates of these conditions among Aboriginal and Torres Strait Islander peoples, the evidence suggests that they have significantly lower access to appropriate health and other services when their additional health service needs are taken into account.^{14, 16}

Further, some police practices - such as the recently introduced, and widely criticised, 'paperless arrests' in the Northern Territory (that allow police to detain people for up to four hours for minor offences)¹⁷ - contribute to the negative cycles that can bring disproportionate numbers

of Aboriginal and Torres Strait Islander peoples into frequent contact with the criminal justice system. Further, there is some evidence that suggests the courts will sentence them more harshly for the same offences when compared to their non-Indigenous peers.¹⁸

For all these reasons, as well as factors unique to each individual prisoner, Aboriginal and Torres Strait Islander peoples' imprisonment rates are rising dramatically. Between the 2014 and 2015 March quarters, Aboriginal and Torres Strait Islander males in prison increased by seven per cent and females by nine per cent.⁴ At the end of the 2015 June quarter, 9940 Aboriginal and Torres Strait Islander prisoners were reported.⁴

Aboriginal and Torres Strait Islander peoples are significantly over-represented in custodial settings. In the June 2015 quarter, they comprised 28 per cent of all sentenced prisoners,⁴ despite comprising three per cent of the population.⁵ The age-standardised imprisonment rate in 2014 was 13 times greater than for non-Indigenous people.³ Aboriginal and Torres Strait Islander females comprised over one-third of all female prisoners in 2014.³

In 2012-2013, Aboriginal and Torres Strait Islander 10 to 17 year olds comprised about 40 per cent of 10 to 17 year olds under youth justice supervision, and 50 per cent of all young people in detention.¹⁹ They are 17 times as likely as non-Indigenous young people to have been under youth justice supervision.¹⁹ And this over-representation gap has increased over recent years.¹⁹



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Aboriginal and Torres Strait Islander children and young people must be a priority in attempts to reduce imprisonment rates. First, nationally, more than one in three Aboriginal and Torres Strait Islander peoples were under 15 years of age (36 per cent) at the time of the 2011 Census.²⁰ Second, for Indigenous persons, contact with the criminal justice system prior to adulthood is a strong predictor for imprisonment as an adult. A study followed 5500 10 to 18 year olds after their 1995 first time appearance in the New South Wales Children's Court: 700 of this cohort were Aboriginal and/or Torres Strait Islander.²¹ By 2003, nine in 10 had made at least one adult court appearance, and over one in three had received an adult custodial sentence.²¹ The study reported that the earlier the age of first contact with the criminal justice system the greater the likelihood of further contact.²¹

And, among adults, there are significantly higher rates of repeat offending among Aboriginal and Torres Strait Islander prisoners. In 2014, four in five were repeat offenders, compared to about three in five of non-Indigenous prisoners.³ About one-third of Aboriginal and Torres Strait Islander entrants had been in prison at least five times before, compared with one-quarter of non-Indigenous entrants.²² And this higher rate of cycling in and out of prison contributes to poorer health outcomes by disrupting continuity of care for health conditions, including those that are the focus of this Report Card.

Violence is the most common offence resulting in the imprisonment of Aboriginal and Torres Strait Islander peoples. In 2014, 35 per cent of Aboriginal and Torres Strait Islander prisoners were charged or convicted with acts intended to cause injury, compared with 16 per cent of non-Indigenous prisoners: double the rate.³ Violence among Aboriginal and Torres Strait Islander peoples is often connected to alcohol use, and they are often victims of alcohol-related violence.^{23, 24} Acquired brain injuries that result in cognitive disabilities, as discussed further below, can be a result.

However, it should also be noted that Aboriginal and Torres Strait Islander peoples are also imprisoned at higher rates than other Australians for 'victimless' crimes such as traffic offences,²⁵ promoting calls for a review of sentencing practices in some instances.²⁶

The connection to mental health disorders

High rates of mental health disorders are reported among Aboriginal and Torres Strait Islander prisoners. A 2008 Queensland study involved 419 Aboriginal and Torres Strait Islander prisoners being clinically assessed for such using the Composite International Diagnostic Interview (CIDI) that draws on criteria for mental health disorders in the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (ICD-10).²⁷ A modified version of the CIDI substance use disorder module was administered, with questions about substance use focused on the 12 months prior to incarceration.²⁷ Substance use disorders can be considered as mental health disorders because they are associated with damage to mental health, for example, depressive and psychotic disorders.²⁸

In the 2008 Queensland study cohort, mental health disorders were detected in 73 per cent of male prisoners and 86 per cent of female prisoners. Substance use disorders were the most common disorder: detected in 66 per cent of the male and 69 per cent of female prisoners. These were often co-morbid with other mental health disorders.²⁷ Conditions detected included anxiety disorders (20 per cent male prisoners; 51 per cent female prisoners of the cohort); depressive disorders (11 per cent; 29 per cent); and psychotic disorders (8 per cent; 23 per cent).²⁷ The reported incidence of trauma is discussed in Text Box 1 below.

Text Box 1: Trauma and Aboriginal and Torres Strait Islander Prisoners

Trauma is not a mental illness, but typically refers to symptoms associated with particularly intense stressful life events that overwhelm a person's ability to cope including, but not limited to, psychotic breakdown and post-traumatic stress. Post-Traumatic Stress Disorder (PTSD) is one manifestation of trauma. The 2008 Queensland study referred to in the text reported 12.1 per cent of Aboriginal and Torres Strait Islander male prisoners and 32.3 per cent of female prisoners with PTSD.²⁷

There is evidence that Aboriginal and Torres Strait Islander peoples with diagnosed mental health disorders have substantially more contact with the police than their non-Indigenous peers. A 2012 University of New South Wales study examined 2731 individuals in New South Wales whose mental health disorder(s) and cognitive disability diagnosis was known, and who had been in prison.²⁹ Of the total study cohort, 25 per cent (676) identified as being Indigenous.²⁹

Across a range of indicators, the Aboriginal and Torres Strait Islander cohort in the study fared significantly worse than their non-Indigenous peers. Overall, the former came into contact with the criminal justice system on average three years earlier (at an average age of 15.3 years of age, and a median age of 14.3 years); with 25 per cent having had their first police contact by age 12.²⁹ First custody also occurred four years earlier than in the non-Indigenous cohort.²⁹

The study reported that compared to non-Indigenous prisoners with diagnosed mental health disorders, Aboriginal and Torres Strait Islander prisoners had, on average, an additional 29 contacts per person over the period of their lives included in the study,²⁹ at an increased rate of 1.7 contacts per year.²⁹ Further, mental health disorders in this cohort are associated with increased recidivism, and with five more episodes of incarceration (although comprised

of much shorter stays in custody) than their non-Indigenous peers.²⁹

A systematic review of eight quantitative studies on the mental health of Aboriginal and Torres Strait Islander prisoners concluded that the available literature suggests high rates of mental problems, and that the rates among women are of particular concern.³⁰ However, studies in this area are few and limited in scope. The review concluded that the first step toward addressing the high rates of mental health problems among Aboriginal and Torres Strait Islander peoples in custody is to systematically identify the nature and extent of these problems.³⁰ The AMA supports this call.

The connection to alcohol and other drug use

Alcohol and other drug use is also associated with offending behaviour and, as noted, alcohol use is associated in particular with violent offending. An analysis of Drug Use Monitoring in Australia (DUMA) project findings over 1999–2005 reported 79 per cent of Aboriginal and Torres Strait Islander peoples tested positive for drugs (including alcohol, cannabis, amphetamines, and heroin) at the time of being detained by police.³¹ The 2009 NSW Inmate Health Survey reported that 55 per cent



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of Aboriginal and Torres Strait Islander male prisoners and 64 per cent of female prisoners reported an association between drug use and their offence.³²

Other analysis of DUMA data (for 2002-2003) along with that from the Drug Use Careers of Offenders (DUCO) project reported over two thirds (69 per cent) of Aboriginal and Torres Strait Islander male prisoners, and 43 per cent of Aboriginal and Torres Strait Islander male police detainees, had used alcohol at the time of arrest or commission of the offence, compared with 27 per cent and 28 per cent respectively of their non-Indigenous peers.³³

Longer-term alcohol addiction is also a contributing factor to crime. The DUCO project reported two and half times as many Aboriginal and Torres Strait Islander prisoners (five per cent) attributing their criminal behavior to alcohol addiction as their non-Indigenous peers (two per cent).³³

Recent reports suggest methamphetamine ('Ice') is replacing alcohol as the drug of choice in some Indigenous communities.³⁴ 'Ice' is associated with increasing levels of violence, particularly domestic violence.³⁵

The connections to cognitive and intellectual disabilities

In the 2012 University of New South Wales study referred to above, 1463 individuals were assessed as having a cognitive disability, defined as an IQ assessed at below 80.²⁹ The study also differentiated people with an intellectual disability (defined in the study as an IQ assessed at below 70).²⁹

Among the cohort with a cognitive disability, 65 per cent of Aboriginal and Torres Strait Islander participants were assessed as having an

intellectual disability, compared to 54 per cent of their non-Indigenous peers.²⁹

Among Aboriginal and Torres Strait Islander prisoners with an intellectual disability, first contact with the criminal justice system was occurring approximately one and a half years earlier than for those without - with a median age of first contact of 13.8 years.²⁹ Over the period of their lives included in the study, they also had on average 17 more police contacts than their non-Indigenous peers, (91 contacts compared to 74).²⁹

Further, of the 1463 individuals assessed as having a cognitive disability, approximately 66 per cent were assessed as having complex needs; that is, with a dual diagnosis with a mental health disorder, or what is described as 'alcohol or other drug problematic use'.²⁹ For those with complex needs, the study noted an association between lower rates of contact with the criminal justice system and higher rates of contact with the support services provided by New South Wales Family and Community Services, Ageing, Disability and Home Care (ADHC).²⁹ And the study authors concluded that Aboriginal and Torres Strait Islander peoples in the cohort had received the lowest levels of support from services.²⁹ This suggests the importance of health and support services in diverting Aboriginal and Torres Strait Islander peoples with cognitive and complex needs from the criminal justice system.

Particularly for people with cognitive and intellectual disabilities involved with the criminal justice system, proper assessment of their disability should occur prior to sentencing to help guide the courts as to whether a non-custodial option is appropriate. This is discussed further in Text Box 2 below.

Text Box 2: The Contact of People with Fetal Alcohol Spectrum Disorders with the Criminal Justice System

Fetal alcohol spectrum disorders (FASD) is an umbrella term to describe 'a range of physical, cognitive, behavioural, and neurodevelopmental abnormalities that result from the exposure of a fetus to alcohol consumption during pregnancy'.³⁶ FASD is entirely preventable if alcohol is not consumed during pregnancy.³⁶

Within FASD, Fetal Alcohol Syndrome (FAS) is a diagnosis with indicators including growth deficiency, distinct facial characteristics, and central nervous system damage.³⁷ Partial Fetal Alcohol Syndrome (pFAS) is a diagnosis where it is known that alcohol was consumed during pregnancy, but the person presents without some or any of the physical symptoms of FAS.³⁷ Individuals with pFAS may be as severely impaired in day-to-day functioning than those with a diagnosis of FAS, as the deficits in brain function may be similar.³⁷

The Lililwan Project is a study designed, in part, to estimate the prevalence of FASD and associated factors in an Aboriginal community – the Fitzroy Valley in the Kimberley, Western Australia.³⁸ About 95 per cent of Aboriginal children born over 2002-2003 in the community were involved.³⁸ FAS or pFAS was diagnosed in 13 of 108 children, a prevalence of 120 in 1000, or 12 per cent.³⁸ Prenatal alcohol exposure was confirmed for all children with FAS/pFAS, including 80 per cent in the first trimester and 50 per cent throughout pregnancy.³⁸

In the 13 diagnosed FAS/pFAS children, the most common functional impairments were attention deficit hyperactivity disorder (ADHD) with or without sensory dysfunction (69 per cent), academic achievement (62 per cent), communication (54 per cent), cognition (50 per cent), memory (50 per cent), and executive functioning (50 per cent).³⁸

In its 2011 inquiry into Indigenous youth in the criminal justice system, the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs heard an estimate that 60 per cent of adolescents with a FASD had been in contact with the criminal justice system, and that Aboriginal and Torres Strait Islander children with a FASD are at particular risk.³⁹ The reasons include offending behaviour related to lower impulsive control, inappropriate reaction to fright or loud noises, inappropriate sexual behaviour, and being taken advantage of by other offenders and involved in criminal activity.³⁹ Once involved with the criminal justice system, they may forget to pay fines or obey court orders, and become further and further enmeshed.³⁹



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Further, a child with FASD is likely to be born into households where alcohol or other drugs might continue to be used by their mother and/or carers including at problem levels. This, and the fact that a child with FASD might exhibit behaviour (particularly ADHD) that his or her parents or carers fail to understand, means an increased risk of poor attachment, neglect, and/or other abuse, compounding the effects of FASD on the child's behaviour.⁴⁰

Without a formal medical diagnosis of a FASD, it is difficult for magistrates to use impaired functioning as a mitigating factor in sentencing, as was formally adopted by the Supreme Court of Western Australia in 2009. Its *Equality Before the Law Bench Book* notes that 'individuals with a FASD who become involved with the criminal justice system may not understand the arrest and court process, will have diminished competency and capacity, and will not fully grasp the severity of the situation. Individuals with a FASD may make false confessions without understanding the legal consequences of such an act'.⁴¹

Best practice for diverting people with a FASD from contact with the criminal justice system is the subject of ongoing research. However, a 2004 evaluation of a project in the United States involving 19 women with a FASD and with an average age of 22 years, suggests that a combination of targeted education, individual case management, and the right support services can be effective in reducing the risks.⁴² Results of this approach included decreased alcohol and drug use, increased use of contraceptives, increased use of medical and mental health care services, and stable housing. The evaluation suggests that individualised management of people with a FASD can be effective in minimising their risk of contact with the criminal justice system as well as risk to health.⁴²

As noted, the AMA supports the development of a national alcohol strategy that includes measures that specifically respond to the particular needs and preferences of Aboriginal and Torres Strait Islander people.⁹ This includes responses to FASD in Aboriginal and Torres Strait Islander communities.

PART 2

HEALTH SERVICES IN THE COMMUNITY AND IN PRISONS

The 2012 National Prisoner Health Data Collection (NPHDC 2012) is the most comprehensive, recent source of prisoner health data available. It includes data collected from 794 prison entrants, about 4000 prisoners visiting prison clinics, and about 9000 prisoners taking medication. It also includes data from 387 prison dischargees (prisoners expecting to be released in the four weeks following the collection).⁴² Around 30 per cent of participants were identified as Aboriginal and Torres Strait Islander peoples.⁴² All States and Territories except Western Australia provided data.⁴²

The reach of health services in the community

In the NPHDC 2012, Aboriginal and Torres Strait Islander prisoner entrants' use of health services in the community in the previous 12 months was lower than their non-Indigenous peers across all services, as set out in Table 1. In contrast, in prison, use is far more even.⁴² In that sense, prison can – perversely – represent an opportunity for Aboriginal and Torres Strait Islander people to improve their use of (or access to) health professionals and improve their health.

Table 1: The use of health professionals by Aboriginal and Torres Strait Islander prisoners and non-Indigenous prisoners in the 12 months prior to imprisonment.⁴²

Health professional	Aboriginal and Torres Strait Islander prisoners (per cent)	Non-Indigenous prisoners (per cent)	Aboriginal and Torres Strait Islander prisoners' use compared to non-Indigenous prisoners' use
GP	56	68	21 per cent lower
Nurse	36	27	33 per cent higher
Alcohol/drug worker	23	25	About the same
Social worker/welfare officer	14	15	About the same
Dentist	13	19	46 per cent lower
Psychologist	12	22	45 per cent lower
Mental health nurse/team	12	15	25 per cent lower
Psychiatrist	10	15	50 per cent lower
Any health professional	68	78	15 per cent lower

For many Aboriginal and Torres Strait Islander people in the community, being able to access culturally safe and competent health care is key to the accessibility and effectiveness of health services:

- culturally safe services are welcoming and otherwise unthreatening services to Aboriginal and Torres Strait Islander people. They acknowledge the socioeconomic and cultural factors influencing the health and wellbeing of Aboriginal and Torres

Strait Islander peoples and place clients at the centre of care.⁴³ The visible presence of Indigenous staff members (such as Aboriginal Health Workers) has been demonstrated to help manage the risk of services unintentionally alienating Indigenous clients;⁴⁴ and

- culturally competent skills in this context enable health workers and professionals to work across cultural differences they may have with an Indigenous client.⁴⁵ Workers can gain culturally competent skills through experience working with Indigenous peoples and/or by training modules.⁴⁶

Researchers have demonstrated that ACCHOs – primary health services developed, delivered by, and accountable to the Aboriginal and Torres Strait Islander communities they serve⁴⁷ – are the preferred providers of services to those communities. ACCHOs provide a culturally safe and competent service.⁴⁸ They are also manifestations of Aboriginal and Torres Strait Islander peoples' right to self-determination. This has been described as an 'ongoing process of choice' to 'ensure that Indigenous communities are able to meet their social, cultural, and economic needs'.⁴⁹

With appropriate resources, an ACCHO is able to implement a comprehensive primary health care model based on the culturally shaped, holistic concepts of health understood by Aboriginal and Torres Strait Islander communities, and

that underpins the approach of these services. That holistic health concept – referred to as social and emotional wellbeing - includes physical and mental health, and an individual's relationships to family, community, land, waters, and ancestors, as well as acknowledging the personal impact of social and historical determinants.¹²

Perhaps not surprisingly, researchers have demonstrated that ACCHOs perform better in the identification of risk factors, performance of health checks, care planning, and the management of health conditions among Aboriginal and Torres Strait Islander clients when compared to general population health services.^{50, 48}

Yet, in the community, many Aboriginal and Torres Strait Islander people do not have access to ACCHOs or culturally safe and culturally competent health care. The Australian Government funded 269 organisations to improve the health of Aboriginal and Torres Strait Islander people and their communities in 2013-2014.¹⁶ ACCHOs comprised 62 per cent of these organisations along with government-operated Aboriginal Medical Services (AMS) and some other services. About six in 10 of the 269 services operated substance-use and drug and alcohol programs.¹⁶

Yet, not enough ACCHOs exist to serve the entire Aboriginal and Torres Strait Islander population, and many are not adequately resourced to meet need. As at 30 June 2011, the Australian

Text Box 3: Access to Acute Care and Hospital Resources in Prison

The focus of this Report Card is on Aboriginal and Torres Strait Islander peoples' access to primary health care in the community and in prison. However, it is also critically important, particularly given the high rates of cardiovascular disease and the risk of heart attacks or strokes among this population group, that timely access to acute care (and other hospital resources) is ensured.



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Bureau of Statistics estimated the population of Aboriginal and Torres Strait Islander peoples to number 669,900 individuals.¹⁶ Yet, the Australian Government-funded organisations that aim to improve the health of Aboriginal and Torres Strait Islander people and their communities (referred to above) are recorded to have only 323,600 Aboriginal and Torres Strait Islander clients.¹⁶

Of these 269 services, 203 were Indigenous primary health care organisations: 139 ACCHOs and 64 AMS (18 other non-government organisations, and 46 government-run organisations).¹⁶ ACCHOs identify as having 327,000 individual clients, of whom 78 per cent were Aboriginal and Torres Strait Islander people.¹⁶

This suggests that just under half (48 per cent) of Aboriginal and Torres Strait Islander people either chose to use, or had access to, these 269 services, and around 38 per cent have access to or choose to use ACCHOs.

A recent spatial mapping exercise by the Australian Institute of Health and Welfare confirmed that a significant number of Aboriginal and Torres Strait Islander communities are without access to any such health services (including ACCHOs).⁵¹ It noted that 61 per cent of these populations reported higher rates of potentially preventable hospitalisations,⁵¹ suggesting the impact of the absence of these services.

But, even where these services exist, there is evidence to suggest that many are not resourced to implement the full comprehensive primary health model discussed above. And the gaps are in areas key to preventing imprisonment. Of the 269 organisations, 61 per cent reported gaps in mental health and social and emotional wellbeing services; and 51 per cent reported gaps in alcohol, tobacco and other drugs, and youth services.¹⁶

Anecdotal evidence suggests that many ACCHOs applied for funding under the *Australian Government's Indigenous Advancement Strategy*⁵²

in order to develop mental health, social and emotional wellbeing, and/or alcohol or other drug programs, but few received new funding.

The situation is further complicated by the split in ACCHO-funding between the Department of Health and the Department of the Prime Minister and Cabinet. The latter funds mental health/ social and emotional wellbeing and alcohol and other drug services, while the former the balance of primary health care services and programs.

For services that aim to offer a comprehensive primary health care service, such a split is artificial. At worst, it might be unnecessarily limiting the access of ACCHOs to needed funds for mental health, social and emotional wellbeing, and/or alcohol or other drug programs.

Working in partnership with ACCHOs, the Australian Government should consider whether a single Department of Health funding stream for ACCHOs, which includes funds for mental health, social and emotional wellbeing, and substance abuse services, will provide a better foundation for the service delivery model these services aspire to than current arrangements.

Access to culturally safe and competent health care in prison

Aboriginal and Torres Strait Islander peoples' generally low access to culturally safe and competent health care in the community is only exacerbated by imprisonment. In the NPHDC 2012, eight in 10 of prisons involved reported 'never' having been visited by an ACCHO or AMS; only 12 per cent reported at least one visit a month; with only one prison in the Australian Capital Territory having weekly visits.²²

Coincident with these results, only seven per cent of Indigenous dischargees reported being sure they had received treatment from an ACCHO or AMS in prison (with 24 per cent unsure, and 69 per cent not receiving any treatment).²²



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In the Victorian Aboriginal Community Controlled Health Organisation's (VACCHO) 2015 report, *Keeping our Mob Healthy In and Out of Prison*, it was reported that, while in Victoria ACCHOs were all located within 55 kilometres of all prisons, they had little or no involvement with Aboriginal and Torres Strait Islander prisoners or prison health services.⁵³ The report notes that one result of this lack of involvement was that no formal notification process between prison health services and ACCHOs was in place to enable an effective transition in health care for released prisoners (the importance of post release care is discussed below).⁵³

A number of reasons were provided to explain the situation. In particular, the need for ACCHOs and prison health services to formally engage each other in constructive partnerships was highlighted. But also significant was the need for greater resources to be provided to ACCHOs if they are to work more effectively in prisons. Indeed, as the report notes, the cost and capacity constraints that sending health workers into prisons places upon ACCHOs is considerable.⁵³

The involvement, or lack of involvement, of ACCHOs in prisons aside, a further concern is that, as reported in the NPHDC 2012, eight per cent of Aboriginal and Torres Strait Islander prisoners reported contact with Aboriginal Health Workers in the community prior to imprisonment. Yet, while in prison, that contact rate drops to five per cent.²² The proportion of female entrants who visited an Aboriginal Health Worker decreased from 10 per cent in the community to zero in prison – in other words, no recorded visits.²²

As a result, the NPHDC 2012 reported that just 45 per cent of Indigenous prisoners on discharge believed that they always received what was termed 'culturally appropriate' care, in prison; a further 17 per cent reported that they sometimes received culturally appropriate care and 15 per cent believed they never received culturally appropriate care.²² Only 22 per cent reported participating in an Indigenous-specific program while in prison.²²

Health clinics in prisons

There are relatively small numbers of Aboriginal Health Workers working in prisons who might ensure the delivery of more culturally safe and competent prison health services: New South Wales, South Australia, and Queensland employed, respectively, seven, two and one full-time Aboriginal Health Workers in their prison clinics according to the NPHDC 2012.²² Overall then, only 10 Aboriginal Health Workers for almost 10,000 Indigenous prisoners were employed in clinics across those parts of the Australian prison system that participated in the NPHDC 2012 (noting that Western Australian prisons did not participate).²²

However, in clinical terms, prison health services offer opportunities to an Indigenous prisoner to make health gains that are not available in the community, at least in part perhaps because of lack of access to ACCHOs or other culturally safe and competent health services.

In particular, it is encouraging that the NPHDC 2012 reported 97 per cent of Aboriginal and Torres Strait Islander people discharged from prison self-reported that they received an initial health assessment upon entry to prison.²² Further, that 46 per cent (compared to 39 per cent of their non-Indigenous peers) received a referral made from that assessment.²²

As called for in our 2006 Indigenous Health Report Card, for all health conditions such screening is important because of the high levels of undetected health conditions in the Aboriginal and Torres Strait Islander population. And, in particular, to detect mental health conditions, substance use disorders, and cognitive disabilities that are associated with higher rates of imprisonment and recidivism.

In the NPHDC 2012, 54 per cent of Aboriginal and Torres Strait Islander people discharged from prison self-reported that their overall health had got a lot better in prison, compared with 29 per cent of their non-Indigenous peers.²² Further, 66 per cent of Aboriginal and Torres Strait Islander discharges reported that their mental health was a lot better than upon entry.²² And this is despite



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the apparent lack of available culturally safe or competent care in prison.

Aboriginal and Torres Strait Islander peoples have significant unmet need for culturally safe and competent health and primary health care in the community, including for mental health and substance use disorders. As a result, there is a significant burden of undetected health conditions, including chronic conditions, in Aboriginal and Torres Strait Islander prison entrants that are detected for the first time. Of particular concern is that this includes health conditions identified as causes of imprisonment (mental health conditions, substance abuse disorders, and cognitive disabilities).

As such, a priority should be extending the reach of culturally safe and competent health care (and that provided by ACCHOs in particular) in community settings. To the degree this is able to meet need around mental health conditions and substance use disorders, as well as help to support people with cognitive disabilities, the AMA believes that it will have the additional benefit of reducing imprisonment rates.

Further, when in prison, Aboriginal and Torres Strait Islander prisoners should have access to culturally safe and competent health care, including that provided by ACCHOs, and by the employment of greater numbers of Aboriginal Health Workers across the system.

Undetected chronic disease

The NPHDC 2012 reported five per cent of Indigenous prison entrants self-reporting that they had ever been told they have cardiovascular disease (CVD)²² and diabetes.²² While this could be attributable to the relatively young age of the Aboriginal and Torres Strait Islander prison population,³ it should be noted that surveys have demonstrated that Aboriginal and Torres Strait Islander people develop the symptoms of chronic disease at younger ages.⁵⁴

When contrasted with the biomedical results of the 2012-2013 *National Aboriginal and*

Torres Strait Islander Health Measures Survey (NATSIHMS),⁵⁴ such low rates of self-reporting, even among a relatively young population cohort, suggests high levels of undetected chronic disease. For example, the NATSIHMS reported that:

- one in four Aboriginal and Torres Strait Islander adults' (25 per cent) blood demonstrated abnormal or high total cholesterol levels according to their blood test results. Yet, of these, only one in 10 people (9.1 per cent) from this group self-reported having high cholesterol as a current long-term health condition;⁵⁴ and
- by blood testing, 11 per cent of participants were detected with diabetes.⁵⁴ While 9.6 per cent had a diagnosis, 1.5 per cent had not.⁵⁴ Almost five per cent of additional participants were found to be at high risk of diabetes.⁵⁴

Given the high burden of undetected conditions in the Aboriginal and Torres Strait Islander population, the role of screening by prison health services is critical. In fact, the NPHDC 2012 reported that two out of five Aboriginal and Torres Strait Islander and non-Indigenous prison discharges were diagnosed for the first time with at least one health condition while in prison at some time.²²

Undetected substance use disorders

As noted, the DUCO project reported five per cent of Aboriginal and Torres Strait Islander prisoners self-attributing their criminal behavior to alcohol addiction.³³ However, the actual burden of substance use disorders could be far higher. A 2012 Queensland study involving 274 Aboriginal and Torres Strait Islander prisoners assessed their alcohol consumption and experience of alcohol-related harms in the year before their incarceration using the Alcohol Use Disorders Identification Test.⁵⁵ By this, 45 per cent were classified as alcohol dependent at that time: almost double the rate of non-Indigenous prisoners (22 per cent).⁵⁵



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The above is also evidence that Aboriginal and Torres Strait Islander prisoners are not accessing alcohol treatment programs according to need. The NPHDC 2012 reported that only 17 per cent of Indigenous discharges accessed a program;²² much lower than the need the 2012 Queensland study above suggests. In fact the NPHDC 2012 reports that consultations with alcohol or drug workers by Aboriginal and Torres Strait Islander prisoners decreased inside prison when compared to the community (from 23 to 11 per cent).²²

Undetected mental health conditions

In the NPHDC 2012, non-Indigenous prison entrants were twice as likely to be taking mental health medication (26 per cent and 13 per cent, respectively)²² despite the significantly greater burden of mental health conditions reported among Aboriginal and Torres Strait Islander people in the community, as discussed in Text Box 4 below.

Text Box 4: Mental Health Conditions Among Aboriginal and Torres Strait Islander Peoples

- **Psychological Distress:** In 2012–13, 30 per cent of respondents to the *Australian Aboriginal and Torres Strait Islander Health Survey* over 18 years of age reported high or very high psychological distress levels in the four weeks before the survey interview.¹⁵ That is nearly three times the non-Indigenous rate.¹⁵
- **Mental Health Conditions:** In the two years to June 2013, the hospitalisation rate for mental health issues for Aboriginal and Torres Strait Islander males was 2.3 times the rate of their non-Indigenous males, and the rate for Aboriginal and Torres Strait Islander females was 1.7 times the rate for non-Indigenous females.¹⁴

Also telling is that in the NPHDC 2012, 29 per cent of Aboriginal and Torres Strait Islander prison entrants self-reported a history of mental health issues.²² But, by the time of discharge, 40 per cent reported this.²² Although the prison entrants and discharges are different cohorts, as an average this represents an increase of 37 per cent in self-reporting. The reason for the increase is not clear, but it is suggested by the AMA that this could be attributed to greater contact with health and mental health services while in prison, that are not otherwise available in the community.

Undetected cognitive disabilities

In the previously discussed 2012 University of New South Wales study involving 1463 individuals who had been in contact with the criminal justice system and assessed as having a cognitive disability,²⁹ only 217 had received support services provided by New South Wales Family and Community Services Ageing Disability and Home Care (ADHC).²⁹ Of this cohort, 79 per cent only became clients of the ADHC after being identified as having a cognitive disability while in prison.²⁹ While disaggregation is not available for Aboriginal and Torres Strait Islander prisoners, the data suggests the significant burden of undetected cognitive



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disabilities across the prison population, and underscores the need for better detection of such by the courts prior to sentencing to enable equitable and otherwise non-custodial sentencing as appropriate.

Post-release

For all prisoners, post-release is a time of significant health risk. A 2007 study reported post-release as an at-risk time for suicide among prisoners in general.⁵⁶ And, for Aboriginal and Torres Strait Islander prisoners, a 2004 Western Australian study reported a significantly increased risk of death when compared to their non-Indigenous peers.⁵⁷ Indigenous females aged 20–40 years old on release were at 3.4 times greater risk of death than other Indigenous females in Western Australia.⁵⁷ Similarly, Indigenous males aged 20–40 years were 2.9 times more likely to die than other Indigenous males in Western Australia.⁵⁷ The causes included cardiovascular disease (CVD), suicide, drug overdose, substance abuse disorder-related causes, and car accidents.⁵⁷

As noted in VACCHO's *Keeping our Mob Healthy In and Out of Prison*, post-release is a particularly critical time for prisoners, and ensuring continuity of care by building better relationships between ACCHOs and prison health services is important. The report cites as promising a 'Transitions Clinic' model developed in San Francisco in 2006 to target the health needs of prisoners on release – particularly those with chronic health conditions (including substance use disorders) and their families.⁵⁸

The model is based on the employment of a full-time health worker in a community health service with a caseload of 30–40 clients transitioning from prison.⁵⁸ The health worker attends pre-release parole meetings and works with a prisoner to schedule a transitional health care appointment within two weeks of each prisoner's release.⁵⁸ In its first 18 months of

operation, 55 per cent of Transitions Clinic ex-prisoners attended their initial appointments, with a six-month follow-up rate of seven per cent, compared with 40 per cent and 46 per cent, respectively, for other prisoners.⁵⁸ The program proved particularly effective in engaging a disproportionately high number of people from a minority background, and highlights the important role of individual case management.⁵⁸

A recently published literature review of the effectiveness of primary health care and social support services in meeting the needs of Indigenous prisoners post-release identified as essential:

- the coordination of post-release support by one agency;
- individually tailored case management;
- a holistic and targeted approach;
- culturally appropriate programs, involving family and friends;
- using reliable and valid instruments to assess client needs; and
- planning that commences upon reception and that continues after release.⁵⁹

To this, the AMA adds that it is important that post-release prisoners are assessed for blood-borne viruses (BBV) that may have been transmitted during incarceration. These are transmitted between individuals through direct contact with contaminated blood or other high-risk body fluids. Transmission of BBV can occur through intravenous drug use and unprotected sex-behaviours that are reported at high levels within the prison environment.²²

Immediate and easily accessible support provided by culturally safe and competent community primary health care services, such as that provided by ACCHOs, is well placed to provide this post-release support role.

PART 3

THE AMA CALLS ON AUSTRALIAN GOVERNMENTS TO:

1. Set a national target for closing the gap in the rates of Aboriginal and Torres Strait Islander imprisonment.

In the AMA's 2012 *Position Statement on Health and the Criminal Justice System*, it recommended that 'Governments address the high rates of the incarceration of Aboriginal and Torres Strait Islander peoples as a priority'.⁸ Here, we recommend the adoption of a national target – optimally in the Council of Australian Governments' 'Closing the Gap' Framework - to reduce imprisonment rates. This call echoes Recommendation 1 of the Aboriginal and Torres Strait Islander Social Justice Commissioner's 2009 *Social Justice Report*;⁶⁰ Recommendation 1 of the National Congress of Australia's First Peoples' Justice Policy;⁶¹ and Recommendation 2 of the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs' 2011 report, *Doing Time – Time for Doing: Indigenous Youth in the Criminal Justice Systems*.³⁹

Such a target could support the Indigenous Affairs priorities (employment, school attendance, and community safety) of the Australian Government and the Indigenous Advancement Strategy.⁵² A prison record, after all, can be a major barrier to employment. Families with members in prison are put under tremendous financial and emotional stress with the major impact being felt by children – potentially affecting school attendance and performance.

Further, inherent in reducing imprisonment rates is reducing violent offending by Aboriginal and Torres Strait Islander people, and thereby making communities safer. As noted, acts of violence are the most common reason for the imprisonment of Aboriginal and Torres Strait Islander people, at double the rate of their non-Indigenous peers. And fellow Aboriginal and Torres Strait Islander people are all too often the victims.

2. Adopt a justice reinvestment approach to fund services that will divert Aboriginal and Torres Strait Islander peoples from prison.

As noted, in its 2006 Indigenous Health Report Card, the AMA called for keeping 'out of prison those who should not be there, principally those with mental health and substance use disorders.'

Further, in its 2012 *Position Statement on Health and the Criminal Justice System*, the AMA recommended that 'concerted efforts be made to establish suitable alternatives to imprisonment for Aboriginal and Torres Strait Islander people in contact with the criminal

justice system, including the expansion of diversionary programs, non-custodial sentencing options, and justice reinvestment programs'.⁸ The AMA also supports the call of the now disbanded National Indigenous Drug and Alcohol Committee to use justice reinvestment principles to fund the diversion of Aboriginal and Torres Strait Islander offenders with substance use disorders into community residential drug and alcohol rehabilitation services instead of incarceration.⁶²



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Justice reinvestment refers to policies that divert a portion of the funds for imprisonment to local communities where there is a high concentration of offenders. The money that would have been spent on imprisonment is reinvested into services that address the underlying causes of crime in these communities.⁶³

The AMA believes that a priority focus of diversion programs should also be on people with mental health conditions, substance use disorders, and cognitive disabilities. As discussed at length, there is evidence that suggests a targeted approach to these health and social issues, in particular, could reduce the risk of these people coming into contact with the criminal justice system. This involves reinvesting in the right community support services and, the AMA believes, particularly in the ACCHOs.

There is a growing movement in Australia advocating for justice reinvestment in Australia. In particular, see the Just Reinvest

NSW campaign⁶⁴ and the Change the Record campaign.⁶⁵

Indeed, such calls have come from within the Australian Government. In 2011, the Senate Legal and Constitutional Affairs Committee reported on its inquiry into the value of a justice reinvestment approach to criminal justice in Australia. Highlighting the potential of such an approach it recommended: 'that the Commonwealth commit to the establishment of a trial of justice reinvestment in Australia in conjunction with the relevant States and Territories, using a place-based approach, and that at least one remote Indigenous community be included as a site'.⁶³ The AMA supports this call, but would like to see a greater commitment to justice investment principles being used to fund early intervention and diversion efforts, particularly for people with mental health problems, substance use disorders, and cognitive disabilities, in Aboriginal and Torres Strait Islander communities.

3. Develop service models to support the expansion of ACCHOs and other services as part of an integrated approach to improving the health of Aboriginal and Torres Strait Islander people in the community (including responding to mental health conditions, substance use disorders and cognitive disabilities based on need) and as a preventative measure to reduce imprisonment rates.

The two key advantages of ACCHOs are better access and a more culturally safe and competent, community-based holistic approach to health. And, as has also been discussed, the reach of culturally safe and competent primary and other health services in the community and in prisons is of critical importance not only to improving the health of Aboriginal and Torres Strait Islander prisoners, but also preventing them from coming into contact with the criminal justice system in the first place, and repeat offending.

As such, the first order of business is to ensure that Aboriginal and Torres Strait Islander people in the community are able to access culturally safe and competent primary health care – preferably that provided by ACCHOs, and, if needed, specialist mental health care and treatment for substance use disorders.

And not just more services, although that is important in areas where they do not exist, but also teams within those services able to work effectively and in a coordinated fashion with other services and professionals. That is, to



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address mental health conditions, substance use disorders, and the problems that can arise as a result of cognitive disabilities, as well as accommodation, employment, and other issues that can exacerbate the risk of imprisonment associated with these conditions. And, because of the higher numbers of Aboriginal and Torres Strait Islander children and young people coming into contact with the criminal justice system, this work also must involve schools, teachers, and other front-line professionals and workers who come into contact with children and young people.

Similar calls have been made for many years now. Recommendation 259 of the RCIADIC was that 'Aboriginal community-controlled health services be resourced to meet a broad range of functions, beyond simply the provision of medical and nursing care, including the promotion of good health, the prevention of disease, environmental improvement, and the improvement of social welfare services for Aboriginal people'.⁶⁶ Further, at Recommendations 264-266, that a particular focus of this expansion be on the provision of mental health services by ACCHOs.⁶⁶

And, in 2015, Recommendation 18 of the National Mental Health Commission's National Review of Mental Health Programmes and Services echoed this call, calling for interdisciplinary mental health and social and emotional wellbeing teams in ACCHOs, as well as specialist Indigenous mental health services, that they can coordinate activities with⁶⁷ – for example, based on the model provided by the Statewide Specialist Aboriginal Mental Health Services (SSAMHS) in Western Australia.⁶⁸

The SSAMHS model, in addition to specialist clinical interventions, involves the family of Aboriginal and Torres Strait Islander clients

and engages traditional healers identified by clients and their families through community networks.⁶⁸ It ensures a culturally safe and competent service.⁶⁸ SSAMHS also provide a career structure to encourage the recruitment and retention of Indigenous staff members.⁶⁸ However, to date, it is not clear if it otherwise has had an impact on imprisonment rates in Western Australia. Further adaption of the SSAMHS model could occur to ensure it too works within a wider system-context that aims to divert people from prison as well as address mental health conditions.

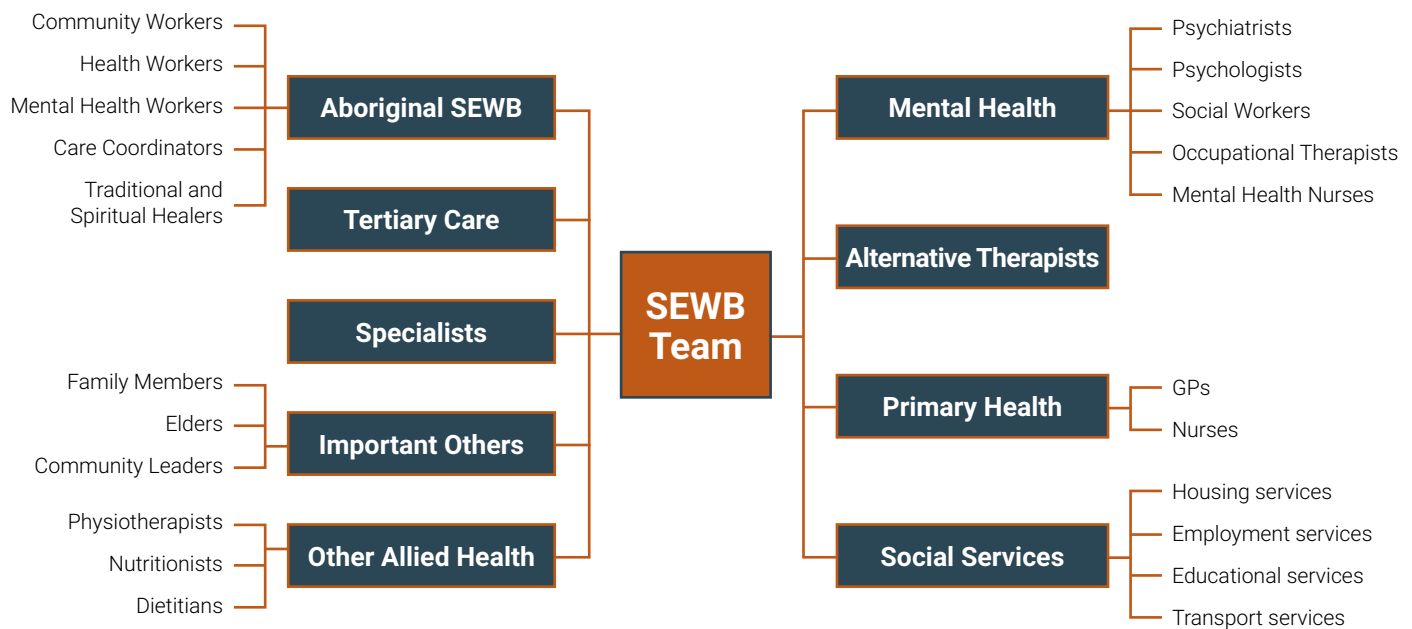
A critical element of the system approach advocated for in this Report Card is the development of a model, or models, for interdisciplinary mental health and social and emotional wellbeing teams within ACCHOs to meet the needs of particular communities. Such a development process should occur under the leadership of ACCHOs working in partnership with Australian governments, and with the communities they serve.

Important work towards the development of such models has already occurred. For example, a model for interdisciplinary social and emotional wellbeing teams was proposed by Schultz and colleagues in the 2014 second edition of the *Working Together Book, Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*.⁶⁹ This text book is intended for staff and students and all health practitioners working in areas that support Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing.

The kinds of capacities and relationships to other support services and professionals encompassed by the model are illustrated in Figure 13.2 below.⁷⁰



Figure 13.2: Potential Members of an Interdisciplinary SEWB Team



Copyright: Schultz et al 2013

Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) has also developed a model for social and emotional wellbeing teams to be based in Aboriginal Medical Services (including ACCHOs), and that aim is to provide integrated health, mental health, and substance abuse services. This is described in Text Box 5.

Finally, the AMA also supports Recommendation 5 of the National Mental Health Commission's Review report,⁶⁷ and the advocacy of Aboriginal and Torres Strait Islander bodies including the National Aboriginal and Torres Strait Islander Leadership in Mental Health,⁷¹ as well as the Close the Gap Campaign,⁷² for a dedicated Indigenous mental health action plan based on the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*, which is currently being developed. Again, such calls have been with us for decades now. Recommendation 264 of the RCIADIC was that: 'there be a substantial expansion in Aboriginal mental health services within the framework of the development, on the basis of community consultation, of a new national mental health policy'.⁶⁶

Text Box 5: AMSANT's Model for Integrated Alcohol and Other Drug, Community Mental Health, and Primary Health Care in Aboriginal Medical Services

In 2009, AMSANT proposed *A Model for Integrating Alcohol and Other Drug, Community Mental Health, and Primary Health Care in Aboriginal Medical Services in the Northern Territory*.⁷³ Critical to the model are 'Social and Emotional Wellbeing Teams' that, for a community of 1500 people, comprises:

- four Aboriginal Family Support Workers (including at least one of each gender) with one position identified as a manager;
- two skilled counsellors able to deliver cognitive behavioural therapy; and
- two of either a mental health nurse or registered Aboriginal Mental Health Worker.

That is in addition to the core primary health care clinical staff of two general practitioners, six nurses, and eight Aboriginal Health Workers.⁷³

Psychologists would be based zonally, with one for every 1500 people. They would provide supervision to counsellors and see those with more complex situations, including addiction, interpersonal violence, and complex problems in young people. There would be one psychiatrist for every 8000 people, based in regional centres.⁷³

The model also deals with Aboriginal and Torres Strait Islander populations of 750, and lower.⁷³

4. In partnership with ACCHOs, prison health services, and other services as appropriate, develop a model of health care that integrates ACCHOs, prison health services, and other services to deliver an integrated approach to service provision that aims to improve health and reduce imprisonment rates at the same time.

This recommendation builds on the previous one – with its focus on expanding the reach of ACCHOs in the community, and the development of interdisciplinary mental health and social and emotional wellbeing teams. With those teams in place, it aims to locate them within an integrated approach that includes prison health services and other services.



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A first step in implementing this recommendation is to clarify the respective roles of the ACCHOs, prison health services, and other services within the integrated approach proposed, and to establish robust relationships between them. As noted, such may require additional resources for ACCHOs if they are to effectively provide outreach services into prisons.

An example of such an approach is based on the Winnunga Holistic Health Care Prison Model developed by the Winnunga Nimmityjah Aboriginal Health Service as a best practice model for holistic health care services for Indigenous prisoners in the Australian Capital Territory (see Text Box 6 below).^{74,75} Critically, it incorporates the goals of diversion, managing release, and preventing recidivism through the lens of health issues. It illustrates how the interdisciplinary mental health and social and emotional wellbeing teams based in ACCHOs or other services, and discussed in Recommendation 3 above, could also be harnessed to reduce imprisonment rates in the communities they work in.

The main features of the model are that:

- in the community, ACCHOs take the lead in identifying Aboriginal and Torres Strait Islander people at risk of contact with the criminal justice system, particularly children and young people, and work with them directly, or coordinate their activities with other services and professionals, to address the health and wellbeing issues that are putting them at risk, including through appropriate combinations of clinical and cultural forms of mental health care, treatments for substance use disorders, and work with cognitive disabilities;

- in custodial settings, ACCHOs providing and/or coordinating continuity of care in partnership with prison health services. This includes continuing with appropriate combinations of clinical and cultural care to address mental health conditions and substance use disorders. Critically, from time of prison entry, it also involves a focus on post-release and addressing the accommodation, employment, and family problems and stigma that can make post-release a time of distress and a high-risk period for suicide; and
- post-release, it proposes continuity of care by the ACCHOs or other services to continue to address health and other risk factors, again with appropriate clinical and cultural care, but this time with a focus on the successful reintegration of prisoners into their communities, and the prevention of recidivism.^{74,75}

This model is aligned with Recommendation 152c of the RCIADIC that recommended the 'involvement of Aboriginal Health Services in the provision of general and mental health care to Aboriginal prisoners.'⁶⁶ It also echoes the National Indigenous Drug and Alcohol Committee recommendation that 'in areas where there are [ACCHOs] or Aboriginal alcohol and drug services, there are opportunities to involve these services in the health care of offenders, and in their ongoing care post-release.' It highlighted in particular, the ability of these services to provide continuity of care from the community to prison and back to community settings.⁷⁶

5. Employ Aboriginal Health Workers and Indigenous health professionals in prison health services to support them to deliver a culturally competent health service.

This could include by the use of workforce targets. For example, the 2006 New South Wales Health *NSW Aboriginal Mental Health Policy 2006 -10* set a target that there be one Aboriginal and Torres Strait Islander mental health workers in 'mainstream' mental health

services for every 1000 Aboriginal and Torres Strait Islander people within the service-area within a set time.⁷⁷ Such targets could also be used to support the employment of Aboriginal Health Workers and health professionals by prison health services.

Text Box 6: The Winnunga Holistic Health Care Prison Model ^{74,75}

The Winnunga Holistic Health Care Prison model has three parts:

1. Incarceration – with ACCHOs working with a range of agencies in the community (Indigenous-specific and otherwise) to provide holistic care during incarceration and working to support active planning for release from time of entry. This includes focus on a prisoner's Indigenous identity, sense of spirituality (taking account of rehabilitation and cultural programs), physical safety while in prison, physical and mental health and continuing care received in the community, and their ongoing connection to family and community. It can involve cultural healers, Elders, 12-step programs, vocational education, and making arrangements for post-release accommodation arrangements.
2. Release from prison – providing post-release health service coordination, and family and community reintegration cycles. This includes a range of spiritual and cultural supports and healing programs, supported accommodation or support for prisoners who return to live with their families, continuing mental and physical health care while in prison, working with the person to access employment, manage parole, and work with shame and social stigma at having served time.
3. Managing the cycle of incarceration – proving early family and other intervention strategies, including those based in culture and spirituality, and particularly for substance abuse and mental health issues.

The model has never been fully implemented, although Winnunga Nimmityjah Aboriginal Health Service maintains an extensive program of weekly prison visits to local prisons. A key element of its approach is providing continuity of care – in many cases, the prisoners it works with in prison were the clients it worked with in the community. And they will resume that relationship on release.

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Medical Ethics in Custodial Settings

2013. Amended 2015¹

1. Preamble

1.1 Prisoners and detainees have a right to humane treatment, regardless of the reasons for their imprisonment, and should be treated with respect for their human dignity and privacy. They should never be denied treatment on the basis of their culture, ethnicity, religion, political beliefs, gender, sexual orientation, the nature of their illness, the reason for their incarceration, or their criminal history.

1.2 In accordance with the World Medical Association, doctors (medical practitioners) must have complete clinical independence in deciding upon the care of a prisoner or detainee for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, should prevail against this. Participation in any form of torture or cruel, inhumane or degrading procedure is incompatible with the doctor's role as healer.ⁱ

1.3 Prisoners and detainees have the same right of access, equity, and quality of health care as the general population. This includes the coordinated and continuous health care from a person's first point of contact with the criminal justice system through to successful reintegration into the community. This also includes continuity of care if a prisoner or detainee is transferred from one custodial setting to another.ⁱⁱ

1.4 Governments and prison authorities have a duty of care to all prisoners and detainees under their control, including those in private correctional facilities. Governments must provide basic humane standards and should strive to achieve world's best practice in all Australian correctional facilities including police custody, prison, juvenile detention centres, and other custodial settings. Correctional facilities should accommodate the language, cultural, and religious needs of prisoners and detainees.

1.5 This position statement highlights important ethical challenges faced by doctors working with prisoners and detainees in custodial settings. It should be read in conjunction with the AMA's *Position Statement on Health and the Criminal Justice System 2012*.²

2. Professional autonomy and clinical independence

2.1 The primary duty of doctors working in custodial settings is to serve the health needs of prisoners and detainees. In order to fulfil this duty, doctors require reasonable professional autonomy and clinical independence without undue influence from correctional facility management.ⁱⁱⁱ At times, the doctor's primary duty may conflict with the priorities of the corrections authorities to enforce prison rules and regulations.^{iv} Corrections authorities should afford doctors the freedom to exercise their professional judgment in the care and treatment of their patients.

2.2 Corrections facilities must provide appropriate medical facilities and resources to care for the health needs of prisoners and detainees.

2.3 Corrections facilities should provide adequate protection and security for doctors and other health care personnel working in custodial settings.

3. Treating doctors and non-treating doctors

¹ In 2015, only Section 12 of this position statement was reviewed and amended.

² For the purposes of this position statement, 'detainee' refers to a person detained in a custodial setting, not in immigration detention. For AMA policy on health care of 'detainees' in immigration detention, please refer to the *Position Statement on Health Care of Asylum Seekers and Refugees 2011*.

3.1 Doctors working in custodial settings may serve as treating doctors or non-treating doctors. The treating doctor has a therapeutic relationship with the prisoner or detainee. The treating doctor's role is to examine, treat, and manage the health needs of their patients (prisoners and detainees) while respecting the confidentiality of information obtained in the course of the therapeutic relationship.

3.2 The non-treating doctor does not have a therapeutic relationship with the prisoner or detainee. A non-treating doctor may be asked to conduct an independent medical assessment to assess the prisoner or detainee on behalf of a third party such as the corrections administration.^v An independent medical assessment may be conducted for a variety of reasons such as assessing a prisoner or detainee's ability to work in the corrections facility. A non-treating doctor may also be asked to conduct a medical examination for judicial, evidentiary, or security purposes.

3.3 Non-treating doctors engaged to perform an independent medical assessment or a medical examination for judicial, evidentiary, or security processes have an obligation to ensure the prisoner or detainee understands the purpose of the examination and its implications and has consented to the examination. The doctor should explain the limits of privacy and confidentiality that may occur in relation to such an examination and provide an objective, impartial opinion.

3.4 Both treating doctors and non-treating doctors working within custodial settings must adhere to the principles of medical professionalism.^{vi}

4. Consent and confidentiality

4.1 Like all patients in the general community, consent should be sought from prisoners before undertaking any examination, diagnosis, or treatment unless the patient does not have decision-making capacity and requires surrogate consent or the situation is an emergency.

4.2 Trust is an essential component of any doctor-patient relationship. Confidentiality of health information should generally be maintained unless the individual consents to disclosure of that information. There may be certain circumstances where disclosure in the absence of consent is appropriate; for example, where non-disclosure poses a serious harm to others or where required by law.

4.3 Effective information management systems and other coordinating mechanisms should be instituted to enable a person's continuity of care (eg., from prison to prison and from prison to the community).ⁱⁱ

5. Body cavity searches

5.1 Body cavity searches for the sole purpose of obtaining evidence or to retrieve substances for evidentiary purposes are not medical acts and should not be undertaken by doctors.

5.2 Body cavity searches for medical purposes should be performed by doctors only. Generally, the person's consent should be obtained before such a search can be undertaken. Doctors may perform body cavity searches on individuals who are unable to consent (due to impaired capacity), only when the life of the person is likely to be endangered.

5.3 Where possible, a doctor from outside the correctional facility should perform body cavity searches.

6. Hunger strikes³

6.1 Doctors should respect a competent individual's decision to enter into a hunger strike. Doctors should continue to provide care to the individual while respecting their voluntary refusal of nourishment.

³ Adapted from the *World Medical Association Declaration of Malta on Hunger Strikers*. Adopted by the 43rd World Medical Assembly, St Julians, Malta, November 1991 and editorially revised by the 44th World Medical Assembly, Marbella, Spain, September 1992 and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006.

6.2 Where a prisoner or detainee refuses nourishment and is considered by the doctor to be capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, the doctor should refuse to co-operate in artificial feeding. Forced feeding contrary to an informed and voluntary refusal is not justifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.

6.3 The decision as to the capacity of the prisoner or detainee to form such a judgment should be confirmed by at least one other independent doctor. The doctors must explain to the person the consequences of the refusal of nourishment, ensuring the person fully understands the information. The doctors should be confident the person is entering into a hunger strike voluntarily.

6.4 Doctors should not apply any undue pressure on the person to suspend their hunger strike. Treatment or care of the individual must not be contingent on them suspending their hunger strike.

6.5 Doctors should communicate with a hunger striker on a daily basis to clarify whether the individual wishes to continue with the strike and what they would like to be done if he/she loses decision-making capacity. Advance refusals of treatment should be respected if they reflect the voluntary decision of the person when competent.

6.6 Where a doctor conscientiously objects to a hunger striker's refusal of treatment, the doctor should make this clear to the person at the outset and refer the hunger striker to another doctor who is willing to abide by the refusal.

7. Solitary confinement and protective custody

7.1 Solitary confinement, where a prisoner or detainee is confined separately from other prisoners or detainees as a means of punishment, is inhumane. Solitary confinement is medically harmful as it may lead to a number of physical and/or mental disorders.

7.2 A prisoner or detainee may need to enter protective custody if at risk of self-harm or of harm by other prisoners or detainees. A prisoner or detainee with a blood-borne or sexually transmitted infection may need to be separated for infection control. Prisoners and detainees should not be separated without adequate access to health care and appropriate medical treatment for any medical condition.

7.3 Correctional facilities should be designed so that prisoners and detainees requiring protective custody can be separated from others in an environment similar to that of the other prisoners and detainees.

7.4 Where a prisoner or detainee in protective custody is isolated from others, the person should be provided opportunities to have regular contact with people outside the correctional facility, either face-to-face or by telephone.

8. Physical and chemical restraints

8.1 The use of force, physical, or chemical restraint solely for non-medical purposes is not a medical act and doctors should not be involved in imposing such restraints.

8.2 Medical personnel should never proceed with medical acts on restrained people, except for those with potential for immediate and serious risk for themselves and others.^{iv}

9. Torture, cruel, or inhumane treatment⁴

⁴ Adapted from the *World Medical Association Declaration of Tokyo – Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*. Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006.



9.1 Doctors must not countenance, condone, or participate in the practice of torture or other forms of cruel, inhumane or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the person's beliefs or motives, and in all situations, including armed conflict and civil strife.

9.2 Doctors must not provide any premises, instruments, substances, or knowledge to facilitate the practice of torture or other forms of cruel, inhumane or degrading treatment or to diminish the ability of the victim to resist such treatment. Doctors should not use nor allow to be used medical knowledge or skills specific to an individual, to facilitate or aid an interrogation.

9.3 Doctors should not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.

10. Medical research

10.1 Doctors must abstain from participating in any form of research involving prisoners and/or detainees without prior ethics approval and adherence to research protocols developed by organisations such as the National Health and Medical Research Council.

11. Speaking out

11.1 Doctors have a duty to speak out to appropriate authorities when the health care services or environment within correctional facilities are inadequate or pose a potential threat to health.

11.2 Doctors should try to prevent coercion or maltreatment of prisoners and detainees and should speak out if such actions occur.

12. Capital punishment

12.1 Doctors must not participate in capital punishment in any way, including facilitating the importation or prescription of drugs for execution, planning, instructing, and/or training of other persons to perform executions.^{vii}

12.2 The AMA does not support capital punishment.

ⁱ World Medical Association. Declaration of Tokyo. *Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*. Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and editorially revised at the 170th Council Session, Divonne-les-Bains, France May 2006.

ⁱⁱ Australian Medical Association. *Position Statement on Health and the Criminal Justice System 2012*.

ⁱⁱⁱ World Medical Association. *Declaration of Seoul on Professional Autonomy and Clinical Independence*. Adopted by the World Medical Association General Assembly, Seoul, Korea, October 2008.

^{iv} World Health Organization. *Health in Prisons. A WHO guide to the essentials in prison health*. 2007.

^v Australian Medical Association. *Ethical Guidelines for Conducting Independent Medical Assessments 2010*.

^{vi} Australian Medical Association. *Position Statement on Medical Professionalism 2010*.

^{vii} World Medical Association. *WMA Resolution to Reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment*. Adopted by the 63rd General Assembly of the World Medical Association, Bangkok, Thailand, October 2012.

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Health Care of Asylum Seekers and Refugees

2011. Revised 2015.

Preamble

The Australian Medical Association affirms that those who are seeking, or who have been granted, asylum within Australia have the right to receive appropriate medical care without discrimination, regardless of citizenship, visa status, or ability to pay. Like all people seeking health care, asylum seekers and refugees in Australia, or under the protection of the Australian Government, should be treated with compassion, respect, and dignity.

The AMA makes the following observations and recommendations in relation to the health care of asylum seekers and refugees:

Health and Welfare of Asylum Seekers and Refugees

1. In addition to suffering the same health problems as the general population, asylum seekers and refugees are at particular risk from a range of conditions including psychological disorders such as post-traumatic stress disorder, anxiety, depression, and the physical effects of persecution and torture. They may also suffer the effects of poor dental hygiene, poor nutrition and diet, and infectious diseases such as tuberculosis, which may be more common in their countries of origin.
2. To determine their specific health needs, all asylum seekers and refugees should undergo comprehensive and timely health assessments in a culturally appropriate manner by suitably trained medical practitioners as part of a primary health care team. This assessment will be used to establish ongoing care with appropriate and descriptive records of asylum seekers' health being recorded on a regular basis to enable multidisciplinary teams and healthcare providers to give effective ongoing care.
3. All asylum seekers and refugees should have access to the same level of health care as all Australian citizens. In addition, it should be ensured that their special needs, including cultural, linguistic, and health-related, are addressed.
4. A national statutory body of clinical experts independent of government should be established with the power to investigate and advise on the health and welfare of asylum seekers and refugees.
5. All asylum seekers and refugees, independent of their citizenship or visa status, should have universal access to basic health care, counseling and educational and training opportunities. Refugees and asylum seekers living in the community should also have access to Medicare and the Pharmaceutical Benefits Scheme (PBS), state welfare and employment support, and appropriate settlement services. Immigration policies that restrict the social and economic rights of disadvantaged groups of people, such as asylum seekers and refugees, can have adverse impacts on their health and wellbeing.
6. Health and welfare service providers for asylum seekers in detention and in the community should have access to translation and interpretive services and be adequately resourced and integrated at state and federal level. This includes increased staff education, training, and support.
7. Refugees, and asylum seekers living in the community, should have continued access to culturally appropriate health care, including specialist care, to meet their ongoing physical and mental health needs, including rehabilitation.
8. More research is needed into the health status and health care of asylum seekers and refugees, both within the community and in detention centres, to assist medical practitioners in the care of these groups, and the development of appropriate services.

9. More research is needed into the impact of immigration controls, such as the prolonged, indeterminate use of detention, on the health of asylum seekers, including those eventually determined to be refugees.

Medical Practitioners

10. Medical practitioners should:

- act in the best interests of the patient;
- not authorise or approve any physical punishment, nor participate in any form of inhumane treatment, nor be called upon to do so by authorities; and
- provide medical treatment in a culturally and linguistically appropriate manner.

11. Medical practitioners should at all times insist that the rights of their patients be respected and not allow lower standards of care to be provided. In particular, the right to privacy and confidentiality must be protected.

12. Appropriate medical treatment teams should include members with the skills outlined below. Medical practitioners providing full assessment of asylum seekers and refugees should be suitably trained in:

- identifying victims of torture and assessment and management of related trauma;
- identification of suicide risk, screening for mental health conditions (including among children and adolescents) and monitoring and management of these conditions;
- responding to the medical, physical, emotional, and developmental needs of children and families; and
- recognising particular health-related conditions which may be more common in an asylum seeker's or refugee's home and transit country than here in Australia (e.g., tuberculosis).

13. Professional medical organisations should develop a set of ethical guidelines to support medical practitioners working with asylum seekers and refugees in whatever context.

14. The primary ethical duty for medical practitioners working with asylum seekers and refugees is to put their patients' health needs first. In order to do this, doctors require reasonable professional autonomy and clinical independence without undue external influence.

15. Doctors should have the freedom to exercise their professional judgement in the care and treatment of their patients and doctors should be supported in seeking guidance and/or discussing the management and care of their patients with peers.

16. Medical practitioners should be able to speak out about unjust, unethical maltreatment of asylum seekers without persecution.

Issues Specific to Asylum Seekers

Immigration Detention Centres

17. Doctors have a duty to speak out when health care services or the environment within an immigration detention centre is inadequate or poses a threat to health.

18. Prolonged, indeterminate detention of asylum seekers in immigration detention centres violates basic human rights and contributes adversely to their health. The longer a person is in detention, the higher their risk of mental illness. Detention in immigration detention centres should be used only as a last resort, and for the shortest practicable time. Solutions to prolonged, indeterminate detention must be sought as a matter of urgency.

19. In order that asylum seekers do not spend a prolonged, indeterminate period of time in detention, the Government must set in law an absolute maximum duration that an asylum seeker can spend in detention. After such time, the asylum seeker should be allowed to live in the community while their visa application continues to be assessed.

20. Where immigration detention centres continue to be used to detain asylum seekers, Government must provide basic humane standards of living conditions. They must strive to achieve world's best practice in all Australian detention centres, whether located within Australia or offshore. This includes accommodating the health, linguistic, cultural, social, educational, privacy, gender-specific and religious needs of asylum seekers.

21. Health and medical services in immigration detention centres should only be provided by organisations, in facilities accredited to Australian standards, that have the full capacity to provide an appropriate range of health and medical care to all detainees as needed, and according to best practice standards in health care delivery (as would apply in the general community). Adherence to these standards should be guaranteed through a process of ongoing monitoring of detainees' health by an independent statutory body of clinical experts with powers to acquire information and investigate conditions in centres as it determines.

22. The assessment and provision of medical care to asylum seekers in detention must be undertaken by medical practitioners.

23. Health screening should be undertaken by a medical practitioner or a nurse. Health screening for addictive, physical, and psychiatric problems, including potential suicide risk, should occur on admission to the centre. All significant medical findings should be referred immediately to a medical practitioner.

24. Medications should be administered by medical professionals or nurses and not detention centre staff, and provisions should be in place for the appropriate management of detainees' medications.

25. Detention centre staff and management should ensure that the instructions provided by medical practitioners for the health and wellbeing of detainees are implemented, documented and maintained efficiently and to Australian standards.

26. Doctors providing services in immigration detention centres should be experienced medical professionals. Where junior doctors are contracted, they must have available to them appropriate medical professional support and advice, and their welfare should be ensured.

27. Continuity of medical care for detainees should be ensured as much as is reasonably possible and steps should be taken to avoid a high turnover of medical and other staff in services provided to detainees.

28. Periodic regular assessment reviews of detainees' health status must occur as appropriate to their health needs.

29. The provision of health care is potentially constrained due to the physical and social environment of detention centres, particularly those located 'offshore'. Those in detention should have timely access to good quality ongoing health care, including emergency and specialist services, to the same standard as is available to Australian citizens. Those who require assessment or treatment that cannot be undertaken within the detention centre environment should be transferred to an appropriate centre in a timely manner.

30. Those in detention should have access to appropriate specialist services including sexual and reproductive health, obstetric and gynaecological services, antenatal and postnatal care, paediatric services, mental health, rehabilitation, allied health services, and dental services.

31. Continuity of care needs to be maintained for refugees and asylum seekers released into the community. They should be fully informed about the Medicare and PBS schemes and how to access

the full range of health care and medical options available in the community. Provision must also be made for ongoing social support services in the community when an asylum seeker is released.

32. Individuals who are released into the community must have timely access to their medical records from their time in detention. Those who are deported should receive a copy of their medical record from their time in detention to take with them.

33. Temporary Visas have negative impacts on asylum seekers' mental health as these visas impose undue stress and anxiety on individuals because they cannot apply for permanent visas and are unable to travel in and out of Australia, or access family reunion schemes. Temporary Visas undermine the ability to successfully integrate into the community.

34. All asylum seekers and refugees should be afforded access to support services, settlement services, employment services and entitlement to family reunion. Failure to access these services have significant negative health consequences.

35. Asylum seekers should not be transferred from one detention facility to another without notice. This can exacerbate their physical and psychological conditions and denies them continuity of care.

36. If a detainee needs to be transferred, their clinical records should be transferred with them to ensure a smooth transition for health needs. Where possible, investigations and treatments should be completed before transfer.

37. Medical practitioners treating asylum seekers who are transferred should be able to provide appropriate handover of relevant documents.

38. Asylum seekers with disabilities are at a particular risk and should receive the same equitable access to appropriate support and health services.

Mothers and Babies

39. Pregnant women held in detention facilities are at a particularly high risk of deteriorating mental and physical health and should receive adequate support services with appropriate pre and post-natal care.

40. Pregnant women should have access to appropriate obstetric and neonatal services for the safety of delivery.

41. While giving birth, women should be afforded privacy and dignity.

Children

42. Detention facilities are unacceptable for children as they create risks for their development, and their physical and mental health.

43. Children are particularly vulnerable and the detention environment places enormous stress on them. Children often witness behavioural and psychological distress in adults, including their parents, violence and self-harm, and experience separation from family members.

44. Children are at a particular risk of sexual violence.

45. An unaccompanied child should never be placed in detention facilities.

46. An accompanied child should be kept in detention facilities for the shortest possible time, but no more than one month. By the end of one month, a suitable placement for the child with at least one adult family member must be identified.

47. Children and their families should be accommodated in separate, safe and appropriate living areas.

48. Families should be prioritised for processing as separation of family members can exacerbate physical and mental conditions.

Hunger Strikers

49. Hunger strikes in detention facilities may be related to the quality of the detention environment or frustration due to ongoing processing issues. The AMA believes such issues should be taken into account in the development of policy and provision of resources for those in immigration detention to try and reduce these situations wherever possible.

50. Where an individual voluntarily refuses nourishment and is considered by a medical practitioner to be capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, the practitioner should be free to refuse to co-operate in artificial feeding. The decision as to the capacity of the individual to form such a judgment should be confirmed by at least one other independent medical practitioner. The practitioners must explain to the individual the consequences of refusal of nourishment.

51. Doctors should become involved with the hunger strikers before, or immediately upon commencement of, a hunger strike in order to continually assess the hunger striker's physical and mental health, counsel the hunger striker regarding the adverse health effects associated with going on a hunger strike, and discuss with the hunger striker his/her wishes regarding artificial nutrition/hydration should he/she lose decision-making capacity. Health staff should have free and unfettered access to hunger strikers, subject to the wishes of a hunger striker with decision making capacity.

52. In accordance with the World Medical Association Declaration on Hunger Strikers (Declaration of Malta), if the hunger striker loses decision-making capacity, the doctor must be free to make treatment decisions that he/she considers to be in the best interests of that particular individual.

53. It is recognised that an individual who takes part in a group hunger strike may feel pressured by the other participants to continue the strike, even if he/she does not want to continue. A hunger striker must be allowed to withdraw from the hunger strike at any time, for any reason.

See also:

AMA Code of Ethics 2004 – Editorially Revised 2006.

World Medical Association Declaration on Hunger Strikers (Declaration of Malta), as editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992.

World Medical Association Declaration of Tokyo, Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment as adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975. and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006.

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