AMA

POSITION STATEMENT ON HEALTH AND THE CRIMINAL JUSTICE SYSTEM

2012

The justice system[i] and public health

There is a strong association between imprisonment and poor health. As a group, prisoners and detainees [ii] have far greater health needs than the general population, with high levels of mental illness, chronic and communicable diseases, injury, poor dental health, and disability.[1,2,3,4] Prisoners tend to be from disadvantaged backgrounds characterised by high levels of unemployment, low educational attainment, drug and alcohol addiction, insecure housing, and illiteracy and innumeracy.[1,5] Over recent decades, the imprisonment rate in Australia has steadily increased. The growth in this rate has been concentrated in particular population groups, disproportionately affecting Aboriginal and Torres Strait Islander peoples, those with mental illnesses, and individuals experiencing socio-economic deprivation. This does not appear to be the result of changing offending patterns, but changes to the way the criminal justice system treats offenders, including a steep increase in the number of prisoners on remand, more punitive sentencing laws and practices, and limited availability of non-custodial sentencing options.[7,8,9,10]

Prison offers access to disadvantaged groups who would normally be hard to reach, and therefore provides an opportunity to address inequalities in health by means of specific health interventions. A significant proportion of those who are incarcerated engage in risky health behaviours, including drug and alcohol use and tobacco smoking.[1,2,11,12,13,14] They are also more likely to be victims of violence or abuse. Many have had little or no regular contact with health services prior to incarceration or detention. Imprisonment can accentuate and further entrench the social and health disadvantages that contribute to incarceration in the first place. Many of those who end up in prison have fallen through gaps in the provision of community-based health and social services, including services for housing[5], mental health, substance use[12], disability , and family violence.[8] Insufficient community-based treatments for substance abuse, mental illness, and co-occurring disorders are key factors driving the growth in the prison population and its disproportionate impact on population groups such as Aboriginal and Torres Strait Islander peoples.[12]

Prisoners' and detainees' access to quality healthcare has important implications for the health of the wider community. With the constant interchange between prisons and the community, health problems and medical conditions experienced in custody become issues of public health for the community when people are released.

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i The term 'justice system' is used throughout this document to refer to both the criminal justice system and the youth justice system.

ii For the purposes of this document, ***prisoners*** are defined as people held in custody under the jurisdiction of an adult corrective services agency. This includes sentenced prisoners serving a term of imprisonment, and unsentenced prisoners held on remand. Young people who are held in a juvenile detention facility are referred to as ***detainees***. Detainees include young people who are either sentenced to custody, or who are remanded to custody in a juvenile justice facility, pending the finalisation of their court matters. Note that these definitions do not encompass immigration detention centres, home detention programs, military prisons, and mental health facilities (unless they are specifically designated as forensic mental health facilities).

Guiding principles

Given the fundamental relationship between public health and the criminal justice system,[16,17] the AMA believes that:

- prisoners and detainees have the same right to access, equity and quality of health care as the general population;
- health services in custodial settings should be resourced and designed to provide a level of care that is commensurate with the health needs of prisoners and detainees and should accommodate the diverse and complex needs of vulnerable and highly disadvantaged subgroups;
- an adequately resourced and nationally coordinated, whole-of-government approach is needed to health in the criminal justice system, which ensures greater consistency of policies and practices across jurisdictions and better integration of health and social support services;
- health service policy and provision in prisons and juvenile detention facilities must be provided independent of corrections authorities;
- the concept of throughcare should be central to the design and delivery of health services, ensuring coordinated and continuous health care from an offender's first point of contact with the criminal justice system through to successful reintegration into the community;
- prisoners should retain their entitlement to Medicare and the Pharmaceutical Benefits Scheme (PBS) while in prison;
- a harm minimisation approach should be incorporated into health policy, services and standards of care in custodial settings;
- the high rates of incarceration of Aboriginal people and Torres Strait Islanders must be addressed as a priority by all levels of government;
- a commitment to addressing the factors that lead to imprisonment and the determinants of poor heath amongst prisoners and detainees needs to be embedded in existing national strategies and intergovernmental agreements relating to public health, mental health, Indigenous health, disability, and homelessness and housing; and
- addressing the association between incarceration and poor health requires investment in upstream measures that address the social determinants of incarceration.

The provision of health care within correctional environments

Responsibility for the provision of health care in prisons and juvenile detention facilities

Addressing prison health within the health portfolio, rather than the corrections portfolio, can foster stronger linkages between prison and community health services. Assigning responsibility to health authorities enables prison health care to be benchmarked with wider health workforce strategies and public health standards; reduces the professional isolation of prison health care staff; and ensures security imperatives do not override health considerations.[18] The separation of the operational functions of prisons and health services also minimises the potential for conflicts of interest that may arise between health delivery and security.

The AMA recommends that:

- responsibility for the provision and management of health care in state-run prisons should be allocated to state health authorities rather than corrective services or their equivalent.

In cases where private providers operate prisons or detention centres:

- prison health services should be independent of the prison operator. If both health and correctional staff are employed by a single private agency, there should be separation of management to ensure integrity of clinical records and professional responsibilities; and
- the seeking of efficiencies and profit should not undermine the provision of health care to prisoners with high care needs, and who may require resource-intensive care and targeted programs.

Health provision based on a principle of 'throughcare'

Throughcare refers to the continuous, coordinated and integrated treatment and management of offenders from their "first point of contact with correctional services to their successful reintegration into the community".[19,20] The continuation of therapies initiated before a person's entry into detention is also an important element of throughcare. Internationally, throughcare is recognised as a best practice approach to working with offenders to reduce recidivism, improve health outcomes, and assist community integration.

The AMA calls for:

- prison and custodial health care services that provide a continuum of health services, supported by effective case management, and underpinned by the principle of throughcare; and
- embedding the concept of throughcare in justice health policies and practices, from the level of systemic planning and the organisation of services, through to everyday operational practices.

Prisoners may be frequently and rapidly transferred between prisons or detention centres, compromising the continuity of care received from a single health service. The AMA recommends that:

- decisions to transfer prisoners or detainees give due consideration to the implications for the provision of health care, and that routine procedures are in place to facilitate the transfer of health information and continuity of care when transfers take place.

Although prisoners experience profound health disparities, they lose their Medicare and PBS entitlements when they enter prison. The need to reapply for a Medicare number upon release is challenging for many prisoners, becomes a major barrier to health seeking, undermines information exchange between prison and community health services, and makes it more difficult to monitor and track the provision of health care within correctional settings. In some jurisdictions, the exclusion of prisoners from the PBS may mean that drug treatment therapies available in the community cannot be accessed within correctional facilities.

The loss of Medicare and PBS entitlements while in prison is inconsistent with best practice in throughcare, and serves to exacerbate the cycle of ill-health experienced by prisoners and detainees as they move between prison and the community.

The AMA recommends that:

- prisoners should retain their entitlement to Medicare and the PBS (including their Medicare Card) while in prison.

Assessment and screening

Contact with the criminal justice system provides a valuable opportunity to detect and address health conditions experienced by prisoners. The AMA recommends:

- upon admission, all prisoners and detainees should receive screening from a medical practitioner for physical, addiction-related and psychiatric disorders, and potential suicide risk. Additional screenings should be undertaken periodically and as an individual is transferred between facilities or different stages of the justice system;
- health assessments should be promptly undertaken to define more fully the nature of health issues identified during screening, and to determine appropriate types of treatment. Health assessments must be undertaken by a medical practitioner or nurse, and mental health assessments should be administered by a trained mental health clinician; and
- health assessments should include evaluation of substance use, hearing loss, acquired brain injury, intellectual disability and other cognitive disabilities given the significant implications these issues have for both health and recidivism outcomes.

Health promotion, early intervention and preventive care

Contact with the justice system provides a unique opportunity to deliver preventive care and early intervention to a population that is otherwise likely to remain outside the reach of services. Prisoners and detainees frequently engage in high-risk behaviours for chronic disease, sexually transmitted infections and blood-borne viruses. [21,13,22] Health promotion and preventive measures that address the common risks factors for these conditions are an essential component of effective prison health care.

The AMA recommends that:

- prevention of illness, early identification and early intervention should be embedded within the operation of the justice system;
- health promotion strategies adopted at a national level should be inclusive of prisons and detention centres, and include input from the prison health care sector;
- immunisation against hepatitis B should be offered to all prisoners and uptake should be actively encouraged; and
- there should be standardised guidelines for the management of nicotine dependence, improved evaluation of smoking cessation programs, and free and equitable access to nicotine replacement therapy for all prisoners nationally.

The design and delivery of health education and promotion activities should be informed by an understanding of the culture, language, literacy, knowledge, attitudes and values of the target group.

Drug and alcohol services

Adequately treating substance use disorders among prisoners enhances the prospects of integration back into the community, thereby reducing recidivism. This also applies to individuals on remand or serving short sentences, and who may be at increased risk of overdose or re-offending upon release.

The AMA recommends that:

- prisoners with substance use disorders should have access to specialist treatment, in accordance with national guidelines, and at least equivalent to those provided in the community. Treatments should include opioid substitution therapy, detoxification programs, and therapeutic community programs;

- there should be mechanisms linking short-term prisoners and detainees with community-based services upon release, and continuity of treatment throughout admission, detention, transfer and discharge;
- accurate identification of disorders and health conditions that co-occur with substance abuse should underpin the development of appropriate treatment plans. Given the high incidence of co-morbid mental and substance use disorders, drug and alcohol services must be effectively integrated into, or coordinated with, mental health services; and
- investing in court or prison alternatives are an effective way of reducing recidivism amongst offenders who have co-morbid substance and mental health disorders.

Harm minimisation

In correctional settings, harm minimisation aims to prevent or reduce the adverse health consequences associated with risky behaviours, such as illicit drug use, tattooing, and sexual activity.

The AMA believes that:

- evidence-based harm minimisation is central to prison health care, and should be incorporated into health policy, services and standards of care in correctional services.

In community settings, the health effectiveness and financial efficiency of Australian needle and syringe programs (NSPs) are well established.[13,23,24] Within correctional settings, such programs have been successfully adopted in a number of overseas jurisdictions and are endorsed by the World Health Organisation.[25]

The AMA supports access within prisons to:

- needle and syringe exchange programs;
- sterilising equipment for tattooing and skin piercing;
- pharmacotherapy programs in accordance with national clinical guidelines (including methadone maintenance therapy);
- treatment and counselling services for alcohol and other drug problems;
- education about HIV, Hepatitis C and other blood-borne and sexually transmitted infections; and
- condoms and dental dams.

Imprisonment increases the risks of sexual and physical assault. Adequate resources should be provided for preventing sexual and physical assaults from occurring in prisons. Appropriate counselling should be provided for those who have been sexually and physically assaulted in prison.

Critical incident monitoring and review should underpin harm minimisation programs. In particular, rape, suicide, assault and illicit substance use should be monitored. The results of such monitoring should be regularly reviewed by an appropriately constituted group, drawn from both health and corrections authorities.

Non-smoking prisoners and detainees should not be exposed to environmental tobacco smoke.[26]

Primary care

Prisoners and detainees should have access to primary care facilities and services that are equivalent in quality to that provided in the community, and commensurate with their heightened health needs. Medical facilities and infrastructure should be appropriately resourced and equipped to deliver timely primary care, and to ensure:

- primary care services in prisons have the capacity for clinical coordination, and include practitioners specialising in mental health and substance misuse; and
- effective information management systems and other coordinating mechanisms are instituted to enable continuity of health care for prisoners who move between correctional facilities, and between correctional and community settings.

Specialist and acute care

To ensure prisoners and detainees with acute needs have timely access to specialist and secondary care, the AMA recommends that:

- where possible, medical specialist and allied health services should be provided on site. Where this is not possible, timely referral and transfer systems should be in place to facilitate access to external medical clinics or hospitals;
- where prisoners or detainees are transferred to hospital, an appropriate balance should be maintained between the demands of patient care and custody. Security measures should be commensurate with the assessed security risk of the patient, and should not compromise the quality of clinical care.

Mental health care

Mental illness is prevalent amongst prisoners and detainees, and has been identified as a central factor contributing to offending and recidivism.[3,8,12,15,27] The rate of co-occurring substance use and mental illness is disproportionately high amongst prisoners, and particularly elevated among women prisoners. Time spent in custody provides opportunities for prisoners and detainees to receive appropriate psychiatric diagnoses and interventions.

The AMA recommends that:

- medical practitioners with suitable qualifications in psychiatry should be involved in the day-to-day management of prisoners with psychiatric disorders. These practitioners should also be represented at the policy and decision-making level in the administration of correctional health care services;
- persons must not be remanded in a correctional facility solely for psychiatric assessment; and
- mental health services in prisons should be adequately resourced to provide appropriate screening, assessment and therapeutic procedures, including for co-occuring mental health and substance use disorders.

Suicide Prevention

Suicide prevention is an essential component of prison health care. The physical environment and operations of the correctional facility should aim to minimise the risk of a detainee or prisoner attempting suicide.

The AMA recommends that:

- each correctional facility should have a suicide prevention strategy, including procedures to systematically screen inmates upon their arrival at the facility and throughout their stay in order to identify those who may be at high risk;
- corrections staff should be trained in suicide awareness and risk assessment, and appropriate systems should be in place to ensure prompt access to appropriate care and effective communication and notification of risk status within and between institutions and prison health staff; and
- a prisoner or detainee who is identified as having a significant risk of suicide should be offered supportive human contact, access and communication with someone trusted, including family members and other appropriate people outside the correctional facility as appropriate. A prisoner or detainee should not be put into seclusion solely on account of their suicidal ideation.

Oral health care

The dental health needs of prisoners and detainees are high compared with the wider community.[1,28] The AMA recommends that:

- routine dental health screening and follow-up care be an essential part of prison health services.

Correctional settings

The physical environment within prisons can shape the health of prisoners and detainees, influencing the success or sustainability of rehabilitation and health interventions.[29,30,31] The World Health Organisation's 'healthy prison' concept reinforces the idea that the health and well-being of prisoners is not the sole responsibility of those providing health care in a prison, but is also dependent upon the regime, physical environment, and ethos of each establishment. Living conditions encompass the physical standards of building and other facilities, levels of hygiene, access to nutritious food, privacy and personal space, classification of prisoners or detainees, and access to opportunities for physical exercise and recreational opportunities.

The AMA recommends that prison policies are instituted to support healthy settings, including:

- protections against harm caused by tobacco smoking (including passive smoking);
- support in adopting healthy behaviours, including appropriate levels of physical activity and a balanced diet; and,
- measures to promote mental health, including adequate time for association, meaningful occupation, and contact with people from outside the corrections environment.

Post-release support

Managing the transition between prison and the community has important health implications for former prisoners or detainees. Prisoners are at a markedly increased risk of death following release from custody, especially in the weeks immediately following release.[19,20] For prisoners who have undergone treatment for substance misuse, the transition from prison to the community is a time of particularly high risk for relapse and overdose.[21,33,34] Resumption of chaotic lifestyles, unemployment, and difficulty accessing primary health services can lead to insufficient and uncoordinated care of multiple health conditions. When basic needs such as shelter and a secure source of income are out of reach, the incentive and capacity to attend medical appointments, maintain medicine regimens, and adopt healthy lifestyles can be severely compromised.

To support better post-release outcomes, the AMA recommends that prison and detention health providers should:

- develop formal linkages with community health services to facilitate transfer of essential information for the patient and the subsequent provider of care, and provision of medicines or a combination of medicines and written prescriptions;
- have ongoing arrangements with community agencies to ensure the continuation of psychiatric care and treatment for substance misuse after release from correctional facilities;
- arrange initial contact with community-based welfare and support organisations; and
- train staff in the specific responsibilities of post-release planning and needs assessment.

Addressing the needs of specific population groups

Aboriginal and Torres Strait Islander peoples

The effects of incarceration and juvenile detention contribute to, and exacerbate, the poor health of Aboriginal and Torres Strait Islander peoples. Although Indigenous persons comprise less than 3 per cent of the Australian population, they make up over 25 per cent of the prison population, and over half of all young people in juvenile detention are from Aboriginal and Torres Strait Islander backgrounds.[6,8,35] These high rates of incarceration and detention are in turn associated with a greater risk of ill-health, substance misuse, chronic and complex health conditions, and premature death. [1,4,8,12,22,36]

The AMA recommends that:

- Governments address the high rates of Indigenous incarceration as a priority;
- concerted efforts be made to establish suitable alternatives to imprisonment for Aboriginal people and Torres Strait Islanders, including the expansion of diversionary programs, non-custodial sentencing options, and justice reinvestment programs;
- Aboriginal and Torres Strait Islander peoples have full access in prison to culturally appropriate primary health care, including management of chronic illness, social and emotional wellbeing, mental health, and drug and alcohol problems;
- Aboriginal and Torres Strait Islander culture is respected in the design and provision of health and medical care in prisons and juvenile detention facilities; and
- access to Aboriginal health workers be expanded across Australia's prison system, and Aboriginal and Torres Strait Islander prisoners and detainees have access to community elders and to relevant representatives of their communities to address their cultural beliefs and needs.

People from non-English speaking backgrounds

Within the criminal justice system, people from non-English speaking backgrounds (NESB) may face linguistic and cultural barriers that impact on their capacity to access healthcare and support, and that compound feelings of isolation, depression, and anxiety.[37] Language barriers can inhibit communication between prisoners and health care providers, thereby compromising diagnosis and treatment.

The AMA recommends that:

- routine access to accredited interpreters be made available for medical appointments, mental health services, and health screening for NESB prisoners or detainees, and for programs that support prisoner health and wellbeing; and
- people who are from NESB backgrounds and are in custodial settings have access to culturally appropriate health care and education programs, and are screened and assessed using culturally appropriate health screening protocols.

Young People

Incarcerated adolescents experience disproportionately high levels of health and social disadvantage.[8,12,38,39,40] While many of these disadvantages mirror those of adult prisoners, young people have distinctive needs regarding their health care. For young people, time in custody provides an opportunity for comprehensive health screening and early and targeted interventions to a group who often have limited access to care and support services when in the community.

The AMA recommends that:

- young offenders are fully screened and assessed when taken into custody, particularly for acquired brain injury, sexual health, hearing, foetal alcohol syndrome disorder, intellectual disability, and other conditions known to be prevalent amongst juvenile detainees;
- rehabilitation and education should be a primary focus of the health care provided to young people in custody; and
- prisoners and detainees under the age of 18 should not be housed in an adult correctional facility.

Women

Female prisoners tend to have more complex substance abuse, physical and mental health issues than male prisoners.[5] Aboriginal and Torres Strait Islander women comprise nearly a third of all women in prison and, as a group, experience some of the most pronounced disadvantages in health outcomes.

The AMA recommends that:

- health services for female prisoners are resourced and designed commensurate to their levels of need, and recognise women's gender-specific health care needs, including access to antenatal, obstetric and post-natal care and gynaecological health services;
- cervical screening and breast cancer checks are readily available, and all new female patients coming into prisons are maintained on existing pharmacotherapy treatment regimes unless clinically indicated;

- where practicable, arrangements are made for infants to be born in a hospital outside the correctional facility, and for the infant to remain with their mother at least until the age of two years, provided that the infant's welfare is not compromised by such arrangements;
- infants born in correctional facilities have adequate nutrition and access to paediatric care, and there should be sufficient facilities for the parent to properly care for the infant, including the provision of play areas, and
- if an infant is born in a correctional facility, this must not be recorded on their birth certificate.

People with a disability

Prisoners with a disability are over-represented in the criminal justice system.[5] These prisoners are more likely to be from an Indigenous background, have co-existing mental health problems, and have had contact with the justice system as a juvenile.[41] The difficulties people with disabilities face in society are often magnified in custodial settings given the closed and restricted environment, and the lack of proper prisoner differentiation and supervision.

The AMA recommends that:

- prisoners with an intellectual or physical disability are provided with relevant services and facilities, including for dual disabilities and/or multiple morbidities associated with disability; and
- the heightened support available to people with disabilities in the broader community through the National Disability Insurance Scheme is available to people with disabilities in prisons.

Early intervention for children with intellectual disabilities, including Foetal Alcohol Spectrum Disorder, is necessary to improve developmental outcomes, minimise the development of secondary disabilities, and reduce the likelihood of future involvement with the criminal justice system.

Data collection, monitoring and evaluation

Sound policy development and planning for health care in the justice system requires robust monitoring and evaluation, with standardised data collection methods and health indicators across all jurisdictions.

The AMA recommends that:

- monitoring and accountability mechanisms should be comprehensive across the justice system and encompass private as well as publicly operated corrections facilities;
- data collected in different jurisdictions should feed into national reporting against standardised benchmarks, with the outcomes used as a basis for continuous improvement in terms of identifying gaps in service delivery, prioritising areas of need, and allocating resources; and
- the privatisation of prisons should not compromise the independence, accountability and quality of prison health care. Contractual arrangements should support rigorous monitoring and accountability mechanisms, including transparency in the allocation of costs, and reporting against benchmarks and standardised health indicators.

References

1 Australian Institute of Health and Welfare [AIHW] (2011). *The health of Australia's prisoners 2010*. AIHW, Canberra.

2 T Butler, D Indig, S Allnutt, H Mamoon, (2011). Co-occurring mental illness and substance use disorder among Australian prisoners. *Drug and Alcohol Review* 30 March:188-194.

3 Ogloff, J, Davis, M, Rivers, G, Ross, S, (2007). The identification of mental disorders in the criminal justice system, *Trends and Issues in Crime and Criminal Justice*, vol. 334, Australian Institute of Criminology, Canberra.

4 R Richmond, K Wilhelm, D Indig, T Butler, V Archer, A Wodak, (2011). Cardiovascular risk among Aboriginal and non-Aboriginal smoking male prisoners: inequalities compared to the wider community. *BMC Public Health* 11:783.

5 M Willis, (2004). *Ex-Prisoners, SAAP, housing and homelessness in Australia: final report to the National SAAP Coordination Committee*. Australian Institute of Criminology, Canberra.

6 Australian Bureau of Statistics, (2012). *Corrective Services, Australia, March 2012*. Catalogue No. 4512.0, Canberra.

7 J Fitzgerald, (2009). *Why are Indigenous imprisonment rates rising?* Issue Paper no. 41, BOCSAR.

8 House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs (2011). *Doing time – time for doing – Indigenous youth in the criminal justice system*. Commonwealth of Australia, Canberra.

9 P Rysavy, T Cunningham, R O'Reilly-Martinez, (2011). Preliminary analysis of the Northern Territory's illicit drug court diversion program highlights the need to examine lower program completion rates for indigenous clients. *Drug and Alcohol Review* 30(6):671-676.

10 M Swartz, (2010). Building communities, not prisons: Justice reinvestment and Indigenous over-imprisonment. *Australian Indigenous Law Review* 14(1):2-17.

11 A Gaffney, W Jones, J Sweeney, J Payne, (2010). *Drug use monitoring in Australia: 2008 annual report on drug use among police detainees*. Australian Institute of Criminology, Canberra.

12 D Indig, C Vecchiato, (2011). *Social determinants of health, risk behaviours and mental health among Aboriginal juvenile detainees*. Paper presented at the Coalition for Research to Improve Aboriginal Health Conference. 5-6 May 2011, Doltone House, Sydney.

13 M Moore, (2011). *Balancing access and safety: meeting the challenge of blood borne viruses in prison*. Public Health Association of Australia, Canberra.

14 T Butler, C Papanastasiou, (2008). *National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey 2004 & 2007*. National Drug Research Institute (Curtin University) & National Centre in HIV Epidemiology and Clinical Research (University of New South Wales).

15 N Hanley, S Ross, (2011). *Mental illness in policy discourse: locating the criminal justice system*. Paper presented at the Australian Political Studies Association Conference, 28-29 September 2011, Canberra.

16 World Health Organisation [WHO], (2003). *Moscow Declaration: Prison health as part of public health*. WHO, Geneva.

17 WHO (2010). *The Madrid Recommendation: Health protection in prison as an essential part of public health*. WHO Regional Office for Europe, Copenhagen.

18 WHO (2010). *Patient or prisoner: Does it matter which Government Ministry is responsible for the health of prisoners?* Briefing paper, WHO Regional Office for Europe, Copenhagen.

19 M Borzycki, (2005). *Interventions for prisoners returning to the community*. Attorney-General's Department, Canberra.

20 M Borzycki, E Baldry, (2003). Promoting integration: The provision of prisoner post-release services, *Trends and Issues in Crime and Criminal Justice*, No. 262, Australian Institute of Criminology, Canberra.

21 S Larney, B Toson, L Burns, Dolan, K, (2011). *Opioid substitution treatment in prison and post-release: effects on criminal recidivism and mortality*. National Drug Law Enforcement Research Fund, Canberra.

22 J Ward, L Topp, J Iversen, H Wand, S Akre, J Kaldor, L Maher, L, (2011). Higher HCV antibody prevalence among Indigenous clients of needle and syringe programs. *Australian and New Zealand Journal of Public Health*; 35(5):234-245.

23 Anex (2010). *With conviction: the case for controlled needle and syringe programs in Australian prisons*. Anex, Melbourne.

24 D Wilson, A Kwon, J Anderson, R Thein, M Law, L Maher L, et al. (2009) *Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia*. National Centre in HIV epidemiology and clinical research, Sydney.

25 WHO, (2007). *Interventions to address HIV in prisons: Needle and syringe programmes and decontamination strategies*. WHO, Geneva.

26 T Butler, C Stevens, C, (2011). *National summit on tobacco smoking in prisons: report on the summit*. National Drug Research Institute, Curtin University, Perth.

27 C Wallace, P Mullen, P Burgess, S Palmer, D Ruschena, C Browne, (1998). Serious criminal offending and mental disorder. *British Journal of Psychiatry* 172:477-484.

28 Osborn, M. and Butler, T. and Barnard, P. 2003. Oral health status of prison inmates - New South Wales, Australia. *Australian Dental Journal* 48(1):34-38.

29 D Whitehead, (2006). The health promoting prison (HPP) and its imperative for nursing. *International Journal of Nursing Studies* 43:123.

30 J Woodall, (2011). Social and environmental factors influencing in-prison drug use. *Health Education*, 112(1): 31-46.

31 C Gately, A Bowen, A Kennedy, W Macdonald, A Rogers, (2006). Prisoner perspectives on managing long term conditions: A qualitative study. *International Journal of Prisoner Health* 2:91-99.

32 WHO, (1999). *Health in Prisons Project*. WHO, Geneva.

33 Larney, S, (2010). Does opioid substitution treatment in prisons reduce injecting-related HIV risk behaviours? A systematic review. *Addiction*; 105(2):216-223.

34 Plugge E, Yudkin P, Douglas N (2009). Changes in women's use of illicit drugs following imprisonment. *Addiction*; 104(2):215-222.

35 Australian Bureau of Statistics, (2011). *Prisoners in Australia* – 2011. Catalogue No. 4517.0, Canberra.

36 National Indigenous Drug and Alcohol Committee (2009). *Bridges and barriers: addressing Indigenous incarceration and health*. Australian National Council on Drugs, Canberra.

37 Centre for the Human Rights of Imprisoned People (2010). *Culturally and Linguistically Diverse Women in Victorian prisons*. Melbourne.

38 Wilson S (2009). *A bridge too far: considering relationships between foetal alcohol spectrum disorders, child protection and the justice system*. Paper presented at the Indigenous young people, crime and justice conference. 31 August - 1 September 2009, Parramatta, NSW.

39 D Kenny, P Nelson, T Butler, C Lennings, M Allerton, U Champion, (2006). *NSW Young People on Community Orders Health Survey 2003-2006: Key Findings Report*. The University of Sydney, Sydney.

40 T Butler, J Belcher, U Champion, D Kenny, M Allerton, M Fasher, (2008). The health of a group of young Australians in a New South Wales juvenile detention centre: A pilot study. *Journal of Paediatrics and Child Health* 33:426-429.

41 E Baldry, L Dowse, M Clarence, (2011). *People with mental and cognitive disabilities: pathways into prison*. Background paper for the National Legal Aid Conference Darwin 2011. University of New South Wales, Sydney.

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