How do Women Leaving Prison in Australia Manage Their Health? An Integrative Literature Review

Donna-Marie Bloice[1], **Adele Baldwin**[1], **Clare Harvey**[2]
[1]*Central Queensland University, Townsville, Queensland, Australia;*
[2]*Massey University, Wellington, New Zealand*

Keywords: *women, prisoners, fragmented care, disengagement, health literacy.*

Summary. *Women leaving prison in Australia experience limited transitional health care and social support which leaves them vulnerable to preventable illness, injury, and death in the community. Many women are victims of violence from a very young age and are homeless, unemployed and engaged in harmful behaviours to cope. These women are at high risk of missed and fragmented care as they disengage from health services and do not follow up with health care appointments or medications once released from prison.*

Design. An integrative review of available Australian peer reviewed literature was conducted to understand the barriers to optimal health care for women, and to inform a model of nursing that would provide continuity of care for women with a diagnosed health condition, post release.

Methods. Using Whittemore and Knafl's integrative review framework as a guide to data analysis and evaluation provided the wide range of concepts relating to barriers and enablers facing women leaving prison. Further, the framework provided the ability to review theories and provided evidence for policymakers to view women leaving prison as a vulnerable group who would benefit from transitional nursing care support.

Conclusion. Women released from prison are at high risk of preventative death and subsequent reincarceration due to cumulative disadvantage. The limited Australian literature evidenced the women's unmet health needs and uncovered the barriers they face in maintaining their health and wellness after a period of incarceration. The review findings support the need for a Nurse Navigator model of care management to provide individualised care management, and promote health and systems literacy, specifically to this group of women.

Introduction

In Australia, the number of women in prison has grown over the past two decades. Women represent 10% of the total prison population (1). The latest statistics provided by the Australian Institute of Health and Welfare (AIHW) (2) show that the female prison population increased by 64% over the past decade, with 48% of women entrants having previously been incarcerated. The social determinants of crime are similar to the social determinants of health, with most people in prison coming from an already marginalised and underserved group in the wider community (3).

Characteristics evidenced by the most recent AIHW (2) report show that women in prison are more likely to be single parents, socioeconomically disadvantaged and experience more challenges to their health and wellbeing than men in prison, and than women in the general community (2). Overall, current evidence shows that women in custody generally experience poorer health outcomes than in the general community with chronic health care needs going unmet, increased reliance on using hospital emergency departments and risk of premature death (4-8). Moreover, the combined effects of multiple chronic health issues may increase recidivism and result in poor treatment outcomes, adding to women's challenges once they leave the prison (8, 9).

First Nations women prisoners accounting for one-third (33%) of the entire female prisoner population (10) are known to cycle in and out of prison more than other Australian women (11). Fifteen per cent of female prison entrants have cycled through prison five or more times, with 43% of First Nations entrants having been incarcerated five or more times. This group of women often have complex health needs including mental health or chronic disease issues and are unlikely to follow up with previously identified health care needs (12) or to access preventative health screening once released from custody (13). This situation contributes to the intergenerational cycle of poverty, poor social circumstances, poor, and fragmented health care as women caught in this cycle disengage from health services (7, 14).

Correspondence to Donna-Marie Bloice, PhD Candidate MNSt, GCCT, BSc, RGN.
E-mail: Donna-Marie.Bloice@cqumail.com

Once released from prison, many women return to deep-rooted lives that include complex health challenges associated with substance misuse, exposure to violence, tobacco smoking and failure to participate in preventative health strategies and continue treatment (7, 11). This group of health care recipients are often poorly educated, commonly have no fixed home or paid employment and may have been diagnosed with a complex physical and or mental health issue while in prison (6). Once released they are expected to manage their own health care needs and navigate multiple, complicated healthcare systems in Australia (6).

In the absence of transitional health care and poor health literacy in this group of women, it is anticipated that their health will continue to deteriorate, adding to a more profound disadvantage (6). There is also clear evidence in the literature that former prisoners are more likely than the general population to die by suicide or other means within one year of leaving prison (6, 15-19). This situation leaves female former prisoners at risk of preventable death in the immediate four weeks post-release (4, 17) and further illustrates the specific health risks associated with incarceration (6), leaving this population vulnerable after release.

The United Nations (UN) 2030 Agenda for Sustainable Development determines that each country must take responsibility for promoting physical, mental, and reproductive health and well-being by achieving access to quality health care for all citizens (20). The UN's vision includes strategies to empower vulnerable women, translating into ending discrimination and violence, but there is little evidence of such a successful strategy. The UN's sustainable goals cannot be achieved without dedicated interventions, adequate discharge planning and transitional care for female prisoners re-entering their communities in Australia. Moreover, the plan to reduce blood-borne viruses and non-communicable diseases is not achieved in this group and requires a person-centred approach to safeguard future generations.

Review Methods

An integrative review using Whittemore and Knafl's approach was undertaken to explore peer-reviewed literature, government documents and grey literature. Whittemore and Knafl's integrative literature review framework identifies the problem, the literature search, data evaluation, data analysis and presentation to conduct the review (21).

This literature review aimed to better understand the factors that influence how women manage their health once released from prison in Australia. The integrative review approach suits this study well as it allows for simultaneous inclusion of experimental and non-experimental research to obtain a fuller understanding of the phenomenon (21). The question that this integrative review sought to answer was:

How are the health needs of women on release from prison in Australia met?

Literature Search Methodology

As a clinician, I wanted to explore what we could do to support women once they leave prison. A search of CINAHL, Embase, ProQuest, Informit and Cochrane databases was conducted using the terms "prisoner health Australia" AND "woman OR women OR female OR females" AND "release from prison." The criteria were limited to Australian results to enable analysis across different health and corrective services that operate under a national agenda.

Each published, peer-reviewed full-text document (n = 59) was read to extract systematically identified data: research participants' characteristics, the methods used to collect the data and methods used to analyse the data, key findings, and how this would link to the research questions. The review checklist tools from the Critical Appraisal Skills Programme (22) (CASP) were used to determine rigour and quality before discarding (n = 23) studies. They did not directly relate to women or former prisoners or the specificity of the research question. Google™ searches (n = 8) comprised government guidelines and reports/briefs. A general Google™ search also provided eight important policy documents and relevant grey literature using the same related terms. The elimination of articles is provided in the PRISMA diagram (23), as outlined in Fig. 1.

Initial evaluation occurred as per the inclusion-exclusion criteria described in Table 1, with a critical appraisal of the literature using relevant CASP (22) tools to determine the methodological quality (24) and included both empirical and theoretical sources (21). The CASP tools include checklists which are valuable in appraising various research designs and methodologies (24).

The review results provided information and context about women's mental health, social experience and risks, which enabled the original published data to be viewed with a fresh interpretation of the phenomenon (25). The variety of perspectives provided insight into complex concepts and illuminated the health care problems which are essential to nursing (21), by identifying that being incarcerated is a form of trauma and can negatively impact a woman's long-term health and wellbeing (26).

Analysis of the Data

I undertook thematic analysis of the evidence to identify recurring themes found in the literature,

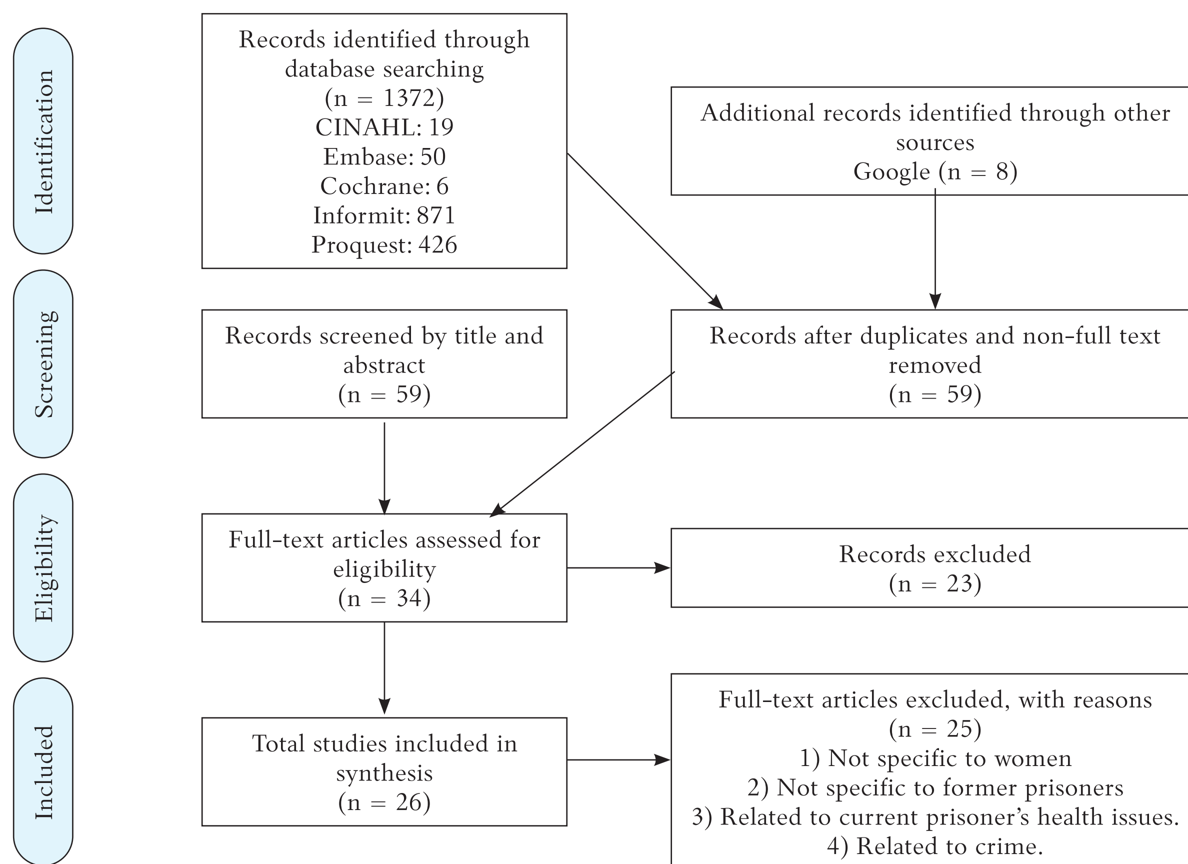

Fig. 1. PRISMA – Flow diagram of search strategy

consistent with an integrative review. Key features of an integrative review are its aim of being critical and the ability to use broad search strategies, which enables the synthesis of both quantitative and qualitative and mixed methods data (21).

A spreadsheet was compiled comprising the selected literature to enable the data to be more easily visualised as interpreted patterns and themes emerged (21). This iterative process of thoroughly examining the data provided a critical analysis strategy to question how the published researcher authors constructed their problem, how they navigated access to the participants, and why there is a dearth of literature regarding follow-up evaluation of the trialled recommendations? Two significant themes emerged from the review. The emerging themes are:

1) "Known to me"
2) (Dis)continuity of care

Table 1. Criteria for selection of literature inclusion

Inclusion criteria	**Exclusion criteria**
Date range 2000–2021	Date range < 2000
Information from Australia only	No other countries included
Study design – any design or methodology which captured the search terms: Prisoner Health Women; Woman; Female; Females relating to release from prison or identified the women as no longer incarcerated, in Australia.	Any study which did not identify the cohort as female; former or released prisoner. Studies which did not report on females in the data. Studies which reported on women currently incarcerated. Studies reporting on youth offenders. Studies reporting on crime related activities.
Government reports and publicly accessible documents relating to Australian prisoner's health in general. Data selection relating to female women's health to provide context and concept when comparing to non-prisoners.	Grey literature and reports which did not relate to women who were released from prison.

Presentation of Findings

Theme 1 – "Known to me"

"Known to me" was the first theme identified in the literature. The theme refers to the women accessing services they know rather than engaging with new services and new providers, regardless of their health needs. The primary health concerns apparent throughout the literature were mental health, harmful behaviours, and preventable deaths in former prisoners (5, 16, 17, 19, 27-29). However, there was minimal discussion in the peer-reviewed papers about strategies for engagement with health services to prevent health deterioration or to improve current health status. Young (30) identified very few preventative measures to support women leaving prison and that interrupted health care can often result in recidivism for women with chronic health needs (8).

The rates at which women return to prison as being greater than men were identified by Abbott et al. (9) as a contributing factor for why some women prisoners view Prisoner Health Services as their regular health facility (7, 14). The very nature of their cycles of incarceration makes the women transient recipients of health care in the correctional setting (7), which often does not provide sufficient time to focus on their needs before being released. For prison health care staff, who are known to the women, it is an opportunity to deal with any unmet physical and mental health needs or health screenings that may be overdue ((7, 14).

Discharge from prison can be challenging and confronting. Often, the unknown element of seeking healthcare on the "outside" may prove to be too daunting for some, particularly those women suffering from an intellectual or physical disability (31). Health management plans, medications, and clinical investigations commenced in prison are left abandoned on discharge, with no follow up once released (9). Many referrals to public health services specialists are booked when the woman is incarcerated (9). However, the women regularly fail to attend these appointments once released (13), which is a further wasted opportunity and worthy of further investigation into what can be done to support the women.

There are multiple barriers for timely access to health care for women once discharged. The reasons specified in the literature include lack of motivation by the women (13); the costs associated with health care (13); disinhibiting effects by drugs or alcohol; loss of family and community connection, unemployment, and stigma (6, 7, 32). In most cases, women's health improves when in prison but commonly fails again once released due to lack of engagement with community health services (8, 33). The women are left to adapt to self-managing within complex health care systems (6), which is a persistent challenge for women who have been incarcerated for intermittent periods of their adult life. Thus, consistent across the literature is that women will engage with services that are known to them that do not increase their already significant levels of vulnerability.

The lack of practitioners in Australia's rural and remote areas is well documented and linked to increasing the social disadvantage of recently released prisoners (6). Remote areas are associated with increased health risks due to lack of access to specialist health services and limited General Practitioner (GP) and mental health clinicians (6). This situation is a significant issue for First Australian women who are already disadvantaged in health outcomes (6) and often live in remote areas. Small remote communities do not always have primary care facilities, leaving the women reliant on acute rural hospital services for critical and non-urgent health needs (6).

While female former prisoners may not engage with primary or preventative health providers, they utilise their local emergency department (ED) for acute healthcare needs (16). This also highlights that it is their preferred choice of provider as they do not have to disclose their previous incarceration (34). Frequent presentations to the ED for injuries sustained during interpersonal violence, intoxication and drug overdose (16) demonstrate the women's vulnerability after leaving prison and suggest reliance on familiar ways of self-managing.

Theme 2 – (Dis)continuity of care

The second theme that emerged in this review describes the women's disengagement with health services after they leave prison. Discontinuity of care leads to fragmentation of care and, unfortunately, poor health outcomes. The identified lack of transitional support for women leaving prison in Australia is a contributing factor to preventable deaths from a drug overdose, suicide, and avoidable co-morbid health conditions (8, 35).

The need for transitional health and social support for women leaving prison has been a consistent recommendation in the literature (4, 5, 34, 36-39) where the advice is to focus attention on preventive efforts and to provide an evaluation of all impacts of interventions. However, there is limited evidence to support any evaluation of measures in the Australian literature (37). Requirements for supportive reintegration and recovery from incarceration should include emotional and physical support from care managers and practical support to obtain housing and financial resources (40). Further, due to inaccuracy in reporting systems across Australian prisons, there is a gross underestimation of the individualised needs of women leaving prison, which adds to the women's disconnect (15).

Chronic health conditions are disproportionately present amongst incarcerated women (7) with many First Nations women experiencing multiple chronic diseases, which positions them at higher risk of deteriorating health and injury after release (14). First Nations women also experience a higher burden of health disparities compared to non-indigenous women (8). There is a dearth of evidence describing culturally orientated approaches to reintegration which could enhance engagement with providers sooner, after release from prison (8, 9).

For women who experience anxiety and depression whilst incarcerated, transition back to their community remains a distressing and challenging time as they re-adjust to their complex social worlds, including legal concerns and family worries (41). After release, women continue to have significant mental health service needs (41, 42), but the literature only discusses those already diagnosed with a known mental health disorder. Not seeking help highlights the need for a holistic approach to mental health and wellbeing beyond diagnosing and treating a specific disorder, that is, the development and implementation of a mental health support plan that includes management of the disorder and the external factors that compound the situation (41).

Many women who leave prison experience fragmented health care and frequently fall between the cracks (5), which adds to the burden of women and the health system by avoidable presentations to emergency departments of public hospitals (6). Additionally, many women have experienced fragmented care before incarceration, which suggests that the health of former prisoners is a public health concern (5, 6, 8), especially for women who use illicit drugs. Substance use is known to have a significant health impact on women and often leads to criminal behaviours, resulting in recidivism (43). Female prisoners are already recognised as one of the most marginalised groups in society, and their risk-taking behaviours of illicit substances add to their disadvantage as they acquire communicable diseases that they may be unaware of until they are confirmed on return to prison (43, 44).

Women moving through the criminal justice system have commonly had poor life experiences, including trauma, abuse, and exposure to violence (45). The role of trauma histories in women has a significant impact in shaping them and their children (45). Many women who have been incarcerated have experienced multiple forms and incidents of violence and acknowledge the role of trauma and victimisation as contributors to their offending (45). However, without access to a wide range of health services and social support, women are more likely to return to lifestyles that first led to their incarceration (40).

The fragmentation of care is apparent throughout the literature, in that, most former prisoners do not attend their primary care GP within the first month of release (8), which can have a significant impact on health outcomes and future engagement. Further, the recidivist cycle offers highs and lows of health care, which may further fragment the already fragmented care (7, 14). The lack of engagement on discharge is also apparent in the failure of women to attend specialist care (8, 9, 38). This has a complex impact on future health care offerings, whereby healthcare providers are less likely to offer future appointments for those who have not attended previously, based on consideration of time and resources.

Abbott et al. (9) provided insights into the poor continuity of care between prison and community health clinicians after release highlighting the lack of professional communication between service providers from the prison to community setting. This situation often results in duplication of services and additional costs from specialist referrals, pathology requests and medical imaging (9). Handover of health information to providers is challenging as many prison health services remain paper-based, limiting the links between healthcare providers (13). Further, given the remoteness of some communities in Australia, the women would benefit from a discharge plan and hand over to include Aboriginal and Torres Strait Islander community-controlled health services to commence before the woman is discharged (7).

It is apparent from the lack of knowledge about women's health access in the literature that there are significant gaps in continuity of care between prisoner health and primary care services (7). Criticism by van Dooren (35) suggests that the exclusive focus of former prisoners' health is on reoffending and reincarceration rather than on their chronic health needs. The over-reliance on using ED rather than available primary care services strongly suggests the need to provide person-centred care management. Ideally, this should involve improving health literacy, self-care, managing chronic diseases, and providing support to navigate specialist out-patient services and avoid missed care (12).

Female former prisoners already possess social and health inequity, often resulting in high reincarceration rates (40). There is a problem of over-reliance on ambulance services amongst former women prisoners (27) and this further highlights the unmet health literacy needs of women who have been discharged from prison. Women with dual health problems of drug use and mental health issues are vulnerable to self-harm or experience suicidal ideation and frequently return to prison (16). This situation emphasises the need for continuity of

care between prison health services and community health care providers.

Women are less inclined to suicide after prison as they resume caring duties for their children or dependents (19). Most women in prison are mothers of dependent children and sentencing a woman to prison will profoundly affect her children (45). The stigma of imprisonment and the often-debilitating labels associated with behaviours result in women and their children losing status in society and experiencing discrimination and less favourable outcomes such as unemployability (40). There is clear evidence in the literature that women leaving prison would benefit from a nursing intervention to ensure they can visit a GP or primary care provider (37).

Discussion

This review did not uncover anything new about the health challenges faced by women on release from prison. However, it reinforced the need for collaborative, strategic approaches to address the urgent need for a nursing intervention, reiterating previous recommendations and drawing attention to the lack of solutions. It could be concluded that the healthcare-seeking behaviours of recently discharged women are an attempt to bridge the gaps between services, and the women's work-around a system that is not working for them.

This cohort is over-represented in statistics related to poor engagement with any government agency, healthcare or otherwise, which is an important consideration in moving forward. Currently, there are a mixture of government and non-government services that provide disjointed services to some female former prisoners in Australia. However, there is no evidence of long-term health planning for women or their children in the Australian literature and simply accepting that they can access hospital care perpetuates the revolving door of hospitalisation and reincarceration (26). The perpetual cycle of recidivism and interruption to good health, lack of understanding about healthy lifestyles and health care access prohibit the women from applying the information to their lives and their ability to make decisions about it. As health issues and self-care go unmanaged, the cycle of entrenched disadvantage could improve with a comprehensive discharge plan, non-prejudiced health care support, and continuity to empower women to engage with primary care services.

Abbott et al. (13) identified the need for increased information sharing and handover from prison to community to support women by reducing the stigma of seeking out healthcare after incarceration and providing continuity of care between prison and community. While in prison, the women are treated as social outcasts by society; they are retained in custody and segregated from society, often being detained far away from family who cannot afford to visit. This disconnection adds to their cumulative disadvantage and structural vulnerability (46, 47) and underestimates costs to the woman physically, emotionally, and her health. The cumulated disadvantage affecting this group of women results in premature mortality (46) and becomes an intergenerational problem affecting the whole family, including the children, due to the accrual and flow-on effect of the multiple social and economic penalties affecting them (48).

Transportation disadvantage is another barrier affecting women with long-term chronic health needs (49), which also impacts the women struggling to meet their legal obligations of reporting to probation and parole offices. Prison does very little for women to pave their way out of disadvantage and contributes to re-traumatisation, shame and stigma (50) as women who have just left prison adopt an "unwanted identity" (51). The women are commonly invisible to health and other services as there are no systems to provide continuity of care or hand over to community providers found in the Australian literature. This situation can often leave them unable to navigate social and cultural expectations. Unlike other women in society who have not experienced the trauma of imprisonment, this position can leave them feeling flawed and unworthy of accepting or seeking support with their needs (51).

Women who experience cumulated disadvantage from debt, housing instability, employability and chronic health issues struggle to resettle back to their communities (50). This disadvantage is a predictor of recidivism (50). One in six women have experienced interpersonal violence since the age of fifteen (52); therefore, some women are repeatedly incarcerated due to their victimisation, poverty, mental health and substance misuse issues.

Central to rebuilding social and health ties with their community, there needs to be recognition and implementation of trauma-informed practices (50) which acknowledge the women's structural vulnerability. Interventions will specifically need to address the complex characteristics and intersecting challenges and oppressions unique to female former prisoners (50). The burden of cumulative disadvantage experienced by female prisoners reinforces the need for them to participate in their own health needs planning. However, any intervention needs to be meaningful to the women considering their literacy and social status rather than current models, which are targeted at people who are able to make rational choice decisions about their health care (47). The purpose of identifying this group of women as structurally vulnerable serves to alert health care providers to the potential need to pursue

the patient (47) and target them to avoid missed and fragmented care. Labelling a woman as structurally vulnerable can positively remove barriers related to the adherence of health plans and make them more visible to providers, thus reducing the stigma of a perceived self-destructive will (47).

The findings of this review suggest the need for an integrated model of nursing to support women leaving prison. The Nurse Navigator model of care (53) fosters a person-centred approach, working across a multi-disciplinary team to provide individualised education to promote health and wellbeing by supporting health and systems literacy. Critical responsibilities of nurse navigation are to reduce hospital avoidance and decrease missed care by failed out-patient attendance (53). Linking a woman with a nurse navigator before release from prison would provide them with a familiar and trusted nurse who will navigate the woman through the unfamiliar health system to good health and wellbeing.

Limitations

Using only Australian literature has narrowed the review's focus to local results. Although there is a reasonable amount of data, evidence, and recommendations obtained from the "Health Passports" study cohort, the information is generalised. It pertains to men and women in most studies. The review would have benefitted from more recent female-specific data found in international peer-reviewed research.

Conclusion

Women released from prison are at high risk of preventative death and subsequent reincarceration due to cumulative disadvantage. The limited Australian literature evidenced the women's unmet health needs and uncovered the barriers they face in maintaining their health and wellness after a period of incarceration. The integrative literature review uncovered women's complex and unique needs, which presented insights into their vulnerabilities and disadvantage. There is a strong suggestion in the literature that women leaving prison could benefit from the Nurse Navigator model of care management.

Conflict of Interest

No conflict of interest has been declared by the authors.

References

1. Australian Bureau of Statistics. Prisoners in Australia ABS; 2021 [Available from: https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release#aboriginal-and-torres-strait-islander-prisoners.
2. Australian Institute of Health and Welfare. The health and welfare of women in Australia's prisons. Canberra: Australian Government; 2020.
3. Stürup-Toft S, O'Moore EJ, Plugge EH. Looking behind the bars: emerging health issues for people in prison. British medical bulletin. 2018;125(1):15.
4. Kinner SA, Forsyth SJ. Development and Validation of a National System for Routine Monitoring of Mortality in People Recently Released from Prison. PLoS One. 2016;11(6):e0157328-e.
5. Kinner SA, Preen DB, Kariminia A, Butler T, Andrews JY, Stoové M, et al. Counting the cost: estimating the number of deaths among recently released prisoners in Australia. Med J Aust. 2011;195(2):64-8.
6. Love AD, Kinner SA, Young JT. Social Environment and Hospitalisation after Release from Prison: A Prospective Cohort Study. Int J Environ Res Public Health. 2017;14(11):1406.
7. Abbott P, Davison J, Hu W. Medical homelessness and candidacy: women transiting between prison and community health care. International Journal for Equity in Health. 2017;16(1).
8. Young JT, Arnold-Reed D, Preen D, Bulsara M, Lennox N, Kinner SA. Early primary care physician contact and health service utilisation in a large sample of recently released ex-prisoners in Australia: prospective cohort study. BMJ Open. 2015;5.
9. Abbott P, Magin P, Lujic S, Hu W. Supporting continuity of care between prison and the community for women in prison: a medical record review. Australian Health Review. 2017;41(3):268-76.
10. Australian Institute of Health and Welfare. The health of Australia's prisoners 2018. Canberra: AIHW: Australian Government; 2019 [Available from: https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/summary.
11. Lloyd J, Delaney-Thiele D, Abbott P, Baldry E, McEntyre E, Reath J, et al. The role of primary health care services to better meet the needs of Aboriginal Australians transitioning from prison to the community. BMC Family Practice. 2015;16(1).
12. Andrade DF, Spittal MJ, Snow KJ, Taxman FS, Crilly JL, Kinner SA. Emergency health service contact and reincarceration after release from prison: A prospective cohort study. Crim Behav Ment Health. 2019;29(2):85-93.
13. Abbott P, Magin P, Hu W. Healthcare delivery for women in prison: a medical record review. Australian Journal of Primary Health. 2016;22(6):523-9.
14. Abbott P, Davison J, Magin P, Hu W. 'If they're your doctor, they should care about you': Women on release from prison and general practitioners. Australian Family Physician. 2016;45(10):728-32.
15. Avery A, Kinner SA. A robust estimate of the number and characteristics of persons released from prison in Australia. Aust N Z J Public Health. 2015;39(4):315-8.
16. Borschmann R, Thomas E, Moran P, Carroll M, Heffernan E, Spittal MJ, et al. Self-harm following release from prison: A prospective data linkage study. Aust N Z J Psychiatry. 2017;51(3):250-9.
17. Forsyth SJ, Carroll M, Lennox N, Kinner SA. Incidence and risk factors for mortality after release from prison in Australia: a prospective cohort study. Addiction. 2018;113(5):937-45.
18. Moore E, Winter R, Indig D, Greenberg D, Kinner SA. Non-fatal overdose among adult prisoners with a history of injecting drug use in two Australian states. Drug Alcohol Depend. 2013;133(1):45-51.
19. Kariminia A, Law MG, Butler TG, Levy MH, Corben SP, Kaldor JM, et al. Suicide risk among recently released prisoners in New South Wales, Australia. Med J Aust. 2007;187(7):387-90.
20. United Nations. Transforming Our World: The 2030 Agen-

da for Sustainable Development A/RES/70/1 New York: UN; 2015 [Available from: https://sdgs.un.org/sites/default/files/publications/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf.
21. Whittemore R, Knafl K. The integrative review: updated methodology. Journal of Advanced Nursing. 2005;52(5):546-53.
22. Critical Appraisal Skills Programme. Critical Appraisal Skills Programme UK. (n.d.). CASP checklists. Retrieved from https://casp-uk.net/casp-tools-checklists/ [Available from: https://casp-uk.net/casp-tools-checklists/.
23. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ. 2021;372:n71-n.
24. Baldwin A, Sobolewska A, Capper T. Pregnant in prison: An integrative literature review. Women and birth : journal of the Australian College of Midwives. 2018.
25. Barnett-Page E, Thomas J. Methods for the synthesis of qualitative research: a critical review. BMC Med Res Methodol. 2009;9(1):59-.
26. Lloyd J, McEntyre E, Baldry E, Trofimovos J, Indig D, Abbott P, et al. Aboriginal and non-aboriginal Australian former prisoners patterns of morbidity and risk of hospitalisation. International Journal for Equity in Health. 2017;16(1).
27. Borschmann R, Young JT, Moran P, Spittal MJ, Heffernan E, Mok K, et al. Ambulance attendances resulting from self-harm after release from prison: a prospective data linkage study. Soc Psychiatry Psychiatr Epidemiol. 2017;52(10):1295-305.
28. Jama-Alol KA, Malacova E, Ferrante A, Alan J, Stewart L, Preen D. Influence of offence type and prior imprisonment on risk of death following release from prison: a whole-population linked data study. Int J Prison Health. 2015;11(2):108-18.
29. Winter RJ, Stoové M, Degenhardt L, Hellard ME, Spelman T, Jenkinson R, et al. Incidence and predictors of non-fatal drug overdose after release from prison among people who inject drugs in Queensland, Australia. Drug Alcohol Depend. 2015;153:43-9.
30. Youngwerth J, Twaddle M. Cultures of interdisciplinary teams: how to foster good dynamics. Journal of palliative medicine. 2011;14(5):650-4.
31. Bhandari A, Dooren K, Eastgate G, Lennox N, Kinner SA. Comparison of social circumstances, substance use and substance-related harm in soon-to-be-released prisoners with and without intellectual disability. J Intellect Disabil Res. 2015;59(6):571-9.
32. High-risk injecting drug use after release from prison [press release]. University of Melbourne: Centre for Research Excellence into Injecting Drug Use2012.
33. Thomas E, Degenhardt L, Alati R, Kinner S. Predictive validity of the AUDIT for hazardous alcohol consumption in recently released prisoners. Drug Alcohol Depend. 2013;134:322-9.
34. Kinner SA, Streitberg L, Butler T, Levy M. Prisoner and ex-prisoner health: Improving access to primary care. Aust Fam Physician. 2012;41(7):535-6.
35. van Dooren K, Claudio F, Kinner SA, Williams M. Beyond reintegration: a framework for understanding ex-prisoner health. Int J Prison Health. 2011;7(4):26-36.
36. Kinner S, Wang E. The Case for Improving the Health of Ex-Prisoners. American Journal of Public Health. 2014;104(8):1352-5.
37. Kinner SA, Alati R, Longo M, Spittal MJ, Boyle FM, Williams GM, et al. Low-intensity case management increases contact with primary care in recently released prisoners: a single-blinded, multisite, randomised controlled trial. Journal of Epidemiology and Community Health. 2016;70(7):683.
38. Kinner SA, Lennox N, Williams GM, Carroll M, Quinn B, Boyle FM, et al. Randomised controlled trial of a service brokerage intervention for ex-prisoners in Australia. Contemp Clin Trials. 2013;36(1):198-206.
39. Kinner SA, Moore E, Spittal MJ, Indig D. Opiate substitution treatment to reduce in-prison drug injection: A natural experiment. Int J Drug Policy. 2013;24(5):460-3.
40. Dias S, Kinner SA, Heffernan E, Waghorn G, Ware R. Identifying Rehabilitation Priorities Among Ex-prisoners Vulnerable to Mental llnesses and Substance Abuse.(Clinical report). The Journal of rehabilitation. 2018;84(3):46.
41. Thomas EG, Spittal MJ, Heffernan EB, Taxman FS, Alati R, Kinner SA. Trajectories of psychological distress after prison release: implications for mental health service need in ex-prisoners. Psychol Med. 2016;46(3):611-21.
42. Alan J, Burmas M, Preen D, Pfaff J. Inpatient hospital use in the first year after release from prison: a Western Australian population-based record linkage study. Aust N Z J Public Health. 2011;35(3):264-9.
43. Degenhardt L, Larney S, Kimber J, Gisev N, Farrell M, Dobbins T, et al. The impact of opioid substitution therapy on mortality post-release from prison: retrospective data linkage study. Addiction. 2014;109(8):1306-17.
44. Winter RJ, Young JT, Stoové M, Agius PA, Hellard ME, Kinner SA. Resumption of injecting drug use following release from prison in Australia. Drug Alcohol Depend. 2016;168:104-11.
45. Wendt S, Fraser H. Promoting gender responsive support for women inmates: a case study from inside a prison. Int J Prison Health. 2019;15(2):126-37.
46. Heap J, Fors S, Lennartsson C. Coexisting Disadvantages in later Life: Demographic and Socio-Economic Inequalities. Journal of population ageing. 2017;10(3):247-67.
47. Quesada J, Hart LK, Bourgois P. Structural Vulnerability and Health: Latino Migrant Laborers in the United States. Med Anthropol. 2011;30(4):339-62.
48. Bruce W, Becky P. Incarceration & social inequality. Daedalus. 2010;139(3):8-19.
49. Northcutt Bohmert M. The Role of Transportation Disadvantage for Women on Community Supervision. Criminal justice and behavior. 2016;43(11):1522-40.
50. Holland J. Treating disadvantage? A gendered exploration of women's offending, post-release experiences and needs. Parity. 2017;30(1):34-6.
51. Brown B. Shame Resilience Theory: A Grounded Theory Study on Women and Shame. Families in society. 2006;87(1):43-52.
52. Coomber K, Mayshak R, Liknaitzky P, Curtis A, Walker A, Hyder S, et al. The Role of Illicit Drug Use in Family and Domestic Violence in Australia. J Interpers Violence. 2021;36(15-16):NP8247-NP67.
53. Byrne A-L, Harvey C, Baldwin A. Health (il)literacy: Structural vulnerability in the nurse navigator service. Nursing inquiry. 2021:e12439-e.

Received January 2022
Accepted April 2022