Public Health Association of Australia:
Prisoner health background paper

This paper provides background information to the PHAA's Prisoner Health Policy Position Statement, providing evidence and justification for the public health policy position adopted by the Public Health Association of Australia and for use by other organisations, including governments and the general public.

Summary statement

Prisoners have poorer health than the general community, with particularly high levels of mental health issues, alcohol and other drug misuse, and chronic conditions. They are a vulnerable population with histories of unemployment, homelessness, low levels of education and trauma. Health services available and provided to prisoners should be equivalent to those available in the general community.

Responsibility: PHAA's Justice Health Special Interest Group (SIG)

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Contents

Prisoner health public health issue

1. The prison population is constantly changing with most prison stays being relatively short and prisoners constantly entering prison and being released from prison back into the community. Therefore the health concerns of prisoners are the health concerns of the general community.
2. Prisoners have poorer health than the general community in Australia, with particularly high and complex needs including alcohol and drug misuse, mental health issues, disability, chronic conditions, histories of trauma and challenging socioeconomic circumstances such as homelessness, low levels of education and unemployment.[1, 2]
3. Prisoners are considered to be geriatric at the age of 50-55 years because of their poor health.[3]

Background and priorities

Public health and social determinants

4. In the June 2017 quarter, there were 41,204 prisoners in Australia, at a rate of 217 prisoners per 100,000 adult population, with one-third (33%) of these prisoners on remand awaiting trial or sentencing.[4] The imprisonment rate in Australia has been increasing steadily over the past decade years from 165 per 100,000 in 2006, [5] including a 40% increase in the number of prisoners over the past 5 years.[4]
5. These prisoners are a highly vulnerable population. Half (49%) have a history of mental health issues, a quarter are currently taking medication for mental health issues, almost one-third (30%) have a long-term health condition or disability limiting their daily activities or participation in education or employment, one-third (32%) have a chronic condition such as diabetes or cardiovascular disease, three-quarters (74%) are current smokers, and 45% have injected drugs.[1]
6. Adding to these health issues are socioeconomic vulnerabilities. One-third (32%) of these adults have completed less than Year 10 at school, almost half (48%) were unemployed before entering prison, and one quarter (25%) were homeless or in short-term or emergency accommodation before prison.[1]
7. As prisoners often come from, and return to, socially disadvantaged communities[6], addressing of the social determinants of health is a priority.
8. Social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. They are responsible for most health inequities – the unfair and avoidable differences in health status seen within and between countries. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.
9. The provision of health services to this population is different to health service delivery in the community in Australia, because prisons are a state and territory responsibility rather than a Commonwealth Government responsibility.

Governance of prison health services

10. The *United Nations Standard Minimum Rules for the Treatment of Prisoners Rule 24* states that:
    a. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.
    b. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.[7]
11. Rule 24 emphasizes the importance of prison health services being equivalent to health services in the community, the responsibility of the state, and governed through the general public health system.
12. In Australia, this means that prison health services should be governed by the relevant State or Territory department responsible for health, rather than the department responsible for custodial services, to ensure that health service provision is independent from the custodial operations.
13. Continuity of care from prison to the community is important given the complex health needs of prisoners. For example, former prisoners visit their general practitioner at twice the rate of the general population, especially those with a history of risky opiate use, mental illness or medications in prison.[8] Integrating prison health services into community health services, is likely to support continuity of care.

National minimum standards for prison health care

14. The provision of health services in prison is difficult as health services must fit in with operational and security considerations, making the goal of equivalence and continuity of care between prison and the community difficult to achieve, particularly at entry to prison and at discharge. For example, uncertainty around discharge dates, applications for bail and parole make it difficult to organise processes and appointments ahead of time in preparation for reintegration into the community.
15. Overcrowding in Australian prisons is a problem as the prison population is increasing[5] and regularly beyond capacity[9]. Movements of prisoners between prisons is a strategy often used to manage overcrowding increasing the difficulty of ensuring continuity of health care service delivery.[10]
16. The difficulties of providing health services in prisons have been noted by the Royal Australian College of General Practitioners in their Standards for health services in Australian prisons. The challenges of the prison environment add to the existing challenges of providing health care to a population with the high and complex needs of prisoners, where good outcomes are already difficult to achieve. Additionally, the high proportion of Aboriginal and Torres Strait Islanders in prison means that there is a strong need for culturally appropriate care.[11]

17. The UN Mandela Rule 25 states that:
    a. Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation.
    b. The health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry. The services of a qualified dentist shall be available to every prisoner.[7]
18. These rules provide guidance on the minimum care that must be achieved within the constraints of the: State and Territory governance; mixture of public and private prisons; difficulties of the prison environment; and complex health needs of prisoners.
19. Currently in Australia, there are no national standards for the delivery of health care to prisoners against which services and outcomes must be measured. These standards are required in order to achieve some consistency and ensure basic levels of service and outcomes are maintained.

Policy priorities

Principles of incarceration -Prison as punishment of last resort

20. Prison should be the punishment of last resort for non-violent and non-sexual crimes with alternatives and diversion from prison and the criminal justice system preferred.
21. Mandatory sentencing has been widely condemned, has no evidence base for deterrence, rehabilitation or reducing recidivism, and has been consistently opposed by the Law Council of Australia.[12]
22. Mandatory and presumptive sentencing are costly in both economic and social terms, and are unlikely to achieve their aims.[13]
23. The risk that removing judicial discretion will reduce fairness in sentencing is recognised by the general community.[14]
24. Mandatory sentences prevent the consideration of personal circumstances and mitigating factors – the same underlying social issues which need to be addressed in order to actually reduce the risk of offending.
25. Criticisms of mandatory sentencing include that: it defies the separation of powers by compromising the independence of the judiciary; they disproportionately affect Aboriginal and Torres Strait Islander people; they risk non-compliance with international human rights laws[15]; their arbitrary nature is in conflict with the rule of law; there is increased risk of disproportionate sentences resulting increase in prison populations.[16]

26. Suitable community-based sentence alternatives should be available throughout Australia, including in regional and remote areas.
27. Being removed from community and support networks is a negative consequence of prison stays, particularly for Aboriginal and Torres Strait Islander people. Visits from family are beneficial for prisoners and are related to reduced re-offending up to 5 years later.[17]
28. The distances to prison can often be prohibitive for families and loved ones, adding to the existing logistical and emotional difficulties involved in visiting prisoners.[18] Replacing short sentences with suitable, local, and culturally appropriate community-based sentencing options would help to alleviate the problems caused by the separations of families through imprisonment.

Diversions from prison

29. Prison diversions including specialist solution focussed courts and programs have been successfully implemented across the world, including in Australia, and work in several ways to reduce over-crowding in prisons, provide appropriate treatment to address health and other needs, and to complement a harm minimisation approach. They typically have broader and higher aims than conventional courts.[19]
30. Operating as specialist courts usually with dedicated Magistrates, diversion programs offer:
    a. a deferred sentencing hearing, providing the offender with the opportunity to demonstrate a commitment to rehabilitation.
    b. Additional support and services with offenders required to complete certain conditions of rehabilitation prior to the sentencing hearing.
31. This is an early intervention approach with voluntary participation, personalised assessment, referral to community-based services, case management by a court based officer, multidisciplinary team based collaboration, use of evidence-based methods, and monitoring of compliance and progress by a dedicated Magistrate at regular review hearings.[20]
32. Programs of these types have been used successfully around the world for offenders with specialist needs including mental health issues, and alcohol and other drug misuse, and are effective in reducing recidivism, and in terms of cost in the medium to long term, especially for adults.[20-22]
33. Drug offenders account for 3-58% of inmates around the world and have higher than average recidivism rates suggesting ineffective treatment while in prison and insufficient referral to treatment on release.[21]
34. Alternatives to prison are supported under UN international drug conventions and provide benefits in reducing both drug use and drug-related crime in a cost-effective way, including by:
    a. decriminalising personal use of illicit drugs,
    b. providing treatment for people with drug use disorders who are in contact with the criminal justice system, and
    c. moving funding from supply-reduction to demand and harm reduction measures. [23]

35. Drug courts need ongoing supervision from the Magistrate or Judge, and consequences for non-compliance, with a continuum of treatment types so they can target treatment to those with the highest need.[21]

Justice targets for Closing the Gap

36. The ongoing over-representation of Aboriginal and Torres Strait Islander people in prisons[5] and youth detention centres[24] in Australia is an urgent concern. In some settings the rates of incarceration are among the highest in the world.[25]
37. In 2016, Aboriginal and Torres Strait Islanders made up over a quarter (27%) of the prison population, despite accounting for just 2% of the general adult population.[5] Aboriginal and Torres Strait Islander people, particularly young females, are more likely to experience short time periods in prison in remand or with short sentences, and are disproportionally represented during a year.[26]
38. Due to incarcerations, 4-15% of men aged 20-39 years are missing from Aboriginal and Torres Strait Islander communities in the Northern Territory at any one time, creating dysfunctions in the population structures and severe social and economic impacts in these communities.[27]
39. A more structured and accountable response would be provided by including a Justice Target as one of the Closing the Gap Targets.

Harm minimisation approach to drug use in prison

40. Australia's National Drug Strategy holds a harm minimisation approach of supply reduction, demand reduction and harm reduction.[28] National Strategies on Hepatitis B, Hepatitis C, HIV, and Sexually Transmissible Infections are also based on harm minimisation approaches.[29-32]
41. Medication assisted treatment for opioid dependence is one evidence based example of a harm minimisation strategy which has been used internationally over many years, in both the community and in prisons. Different treatment options are available combining psychosocial support with the medication designed to eliminate withdrawal, control or eliminate cravings, or block the euphoric effect of opioid use.[33] For example, a randomised controlled trial found that prisoners who were initiated onto buprenorphine were more likely to undergo treatment in prison and also to enter community based treatment after release than prisoners randomised into a counselling only option.[34]
42. Bloodborne virus (BBV) and sexually transmissible infection (STI) prevention uses a range of public health harm reduction strategies in community services including: testing and vaccination, access to sterile injecting equipment through needle and syringe programs and safe injecting facilities, access to condoms, and latex gloves, and sexual health education campaigns and interventions. These measures are recommended for prisoners who are at increased risk of BBV and STIs, and risky sexual behaviour.[35]

Current situation - Australia

Access to Medicare Benefits Scheme and Pharmaceutical Benefits Scheme

43. The Commonwealth Government's Medicare Benefits Scheme and Pharmaceutical Benefits Scheme (known collectively as Medicare) provide payments and services for health care services and medicines. Section 19 (2) of the Health Insurance Act 1973 (Commonwealth) which governs Medicare states that: Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf or, or under an arrangement with:
    (a) The Commonwealth
    (b) A State
    (c) A local governing body or
    (d) An authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory.[36]
44. With prison health provided by the state or territory, prisoners are excluded from Medicare on the basis that funding would constitute 'double dipping', because Medicare is Commonwealth funding. This assumes that the health services provided in prison are compliant with the Mandela Rule of being equivalent to community health services. Where this is not the case, the provision for Ministerial exemptions allows for situations where the exclusion under Section 19(2) causes disadvantage. This exemption has been used in the past, for example in some rural and remote areas.[37]
45. Excluding prisoners from receiving Medicare rebates has been criticised as breaching human rights, resulting in suboptimal health care, and perpetuating the cycle of ill health and disadvantage, and the underinvestment in prison health services means that some prisoners may miss out on specific treatments and medications.[38]
46. Two specific examples where prisoners do not receive health services equivalent to the community are:
    a. Medicare item number 715 is a Health Assessment for Aboriginal and Torres Strait Islander people.[39] No exemptions have been granted to prison health services, and no equivalent culturally appropriate health assessment in prisons exists.[40]
    b. Since 2011, psychological services have been available with Medicare rebates for up to 10 individual and 10 group allied mental health services each year.[41] Prison service are usually limited to those with the most severe need and with limited options for ongoing counselling.[40]
47. Under s19 (2), the Minister could grant exemptions to the exclusion of prisoners for specific items such as these where prisoners are disadvantaged.

Diversion from prison policy

48. Diversion from prison in the form of solution focused courts, operates in most jurisdictions in Australia:
    a. In 2016, specialist courts or lists for drugs and mental health operated in all jurisdictions except the Northern Territory, Australian Capital Territory and Queensland.
    b. There are also specialist courts for family violence, prostitution, teenagers, truancy, welfare fraud and community courts in various jurisdictions.
    c. Drug Courts, Special Circumstances Court list (for homeless and mentally impaired offenders) and Murri Courts were all closed in Queensland in 2012, as was a Youth Drug Court in New South Wales.[20]
49. Mental health diversion courts in South Australia have been found to reduce the rate and severity of re-offending for those successfully completing the program and even those not fully completing it had a reduced risk of re-offending. Appropriate community follow-up care prior to discharge from the program was recommended to maximise the benefits.[42]
50. Australia leads the world in court innovation for Indigenous sentencing court programs.[43] The first Aboriginal and Torres Strait Islander sentencing court program in Australia was established in Port Adelaide in June 1999, and since 2006 they have been operating in various forms in all Australian jurisdictions except Tasmania.[19]
51. Aboriginal and Torres Strait Islander programs combine elements of conventional sentencing processes with agreed practices or protocols for the inclusion of local elders. Common elements include: use of dialogue in a circle rather than the usual elevated position for judicial officers; the offender must be Aboriginal or Torres Strait Islander, plead or be found guilty and consent to the program; and the Magistrate retains the ultimate sentencing power.
52. These specialist courts have both community-building and offending centred aims, and seek to increase the participation and involvement of Aboriginal and Torres Strait Islander community members, victims and offenders in the sentencing process, and increase the confidence of the local communities in the court processes and criminal justice system.[19]

Harm minimisation approach to policy in Australia

53. The degree to which Australia's harm minimisation approach extends to prison health services differs by jurisdiction. Medication assisted treatment for opioid dependence is available for prisoners in all jurisdictions, but with differences in the types of treatment and circumstances under which it is available.[1]

54. Harm reduction measures for sexually transmissible infections such as condoms and dental dams are available in prisons in Australia, but differ among the jurisdictions in terms of ease of anonymous access. Condoms have been available to prisoners in New South Wales for a number of years with prisoner health benefits and without any negative effects in the longer term for the operation of the prison.[44]
55. The Australian Capital Territory Government investigated a needle and syringe program (NSP) trial in the Alexander Maconochie Centre (AMC) prison based on a 2011 evaluation of their drug policies and services.[45] A PHAA government commissioned report recommended suitable models and consultation processes based on international experience.[46] However, the trial stalled with the 2015 Government announcement that no trial would proceed without the approval of a majority of prison officers.[47]

Current situation - internationally

Diversion from prison policy

56. The first modern solution focused courts were established in Florida, in the United States of America, with a drug court in 1989, and a mental health court in 1997. Programs are now established in for neighbourhood courts, veterans courts, drink driving courts, and prostitution courts in countries including Canada, England, Wales, New Zealand, Germany and Brazil.[20]
57. The electronic monitoring of offenders as an alternative to prison or for early release from prison is now an established and regularly applied measure in more than 30 countries worldwide.[48] Global position system (GPS) technology, which is the form of electronic monitoring used in Australia, is more likely to reduce recidivism and detect parole violations, and is less expensive than incarceration.[48]

Harm minimisation approach

Needle and syringe programs

58. Needle and syringe programs (NSP) have successfully operated in prisons around the world for over 20 years. In 2015, eight countries had prison NSPs, and another 74, including Australia, provide NSPs in the community but not in prison.[49]
59. Countries as diverse as Spain, Luxembourg, Moldova, and Kyrgyzstan have prison programs in place which have reduced the spread of BBV, facilitated entry into drug treatment programs, and contributed to workplace safety without a single recorded instance of needle stick injury or increases in drug use or availability since their implementation.[50]

Naloxone on release from prison

60. Naloxone, an opioid antagonist, has no clear potential for misuse, and can be administered by non-medical people with minimal training. It has been used in take-home packs to prevent overdose deaths in the community for the past 20 years.

61. Raised as an idea at the 3rd International Harm Reduction Conference, since 2011, there are now programs in Australia, Canada, 9 European countries, and the United States of America, plus pilots in Afghanistan, China, India, Kazakhstan, Kyrgyzstan, Russia, Tajikistan, Thailand, Ukraine, Vietnam.
62. Naloxone was added to the Pharmaceutical Benefits Scheme in Australia in December 2012, and has been available over the counter since February 2016.
63. In the first 3 years of operation in Australia, there were 57 recorded successful overdose reversals.[51]
64. The period immediately after release from prison is known to be one of high risk for drug overdose and death for ex-prisoners.[52] With this in mind and with the success of community naloxone, trials and programs have been established in both the United Kingdom and United States of America.
65. Difficulties exist with trying to establish a program of take-home naloxone for prisoners on release including:
    a. negative and confused perceptions of such programs among both prison staff and prisoners including how it fits in with attempts to use prison as an opportunity to address drug misuse
    b. the difficulty of identifying and engaging with eligible prisoners
    c. engagement of senior prison staff in the program, and
    d. the processes in individual prisons must be taken account of for effective distribution to occur.[53]
66. The benefits of such a program are evident. Scotland introduced a National Naloxone Program which included distribution of naloxone to prisoners prior to release resulting in 36% reduction opioid related deaths in the four weeks following release since 2011.[54]

Decriminalisation of drugs

67. In 2001, Portugal decriminalised personal use of drugs. The possession and sale of drugs remained illegal but possession of up to a 10 day supply is considered for personal use and is redirected to the Commission for the Dissuasion of Drug Addiction instead of prosecuted. The Commission Committees of social workers, doctors and legal advisors, assess the level of dependence and direct the person to appropriate treatment. Decriminalisation was accompanied by increases in resources for treatment, harm reduction, and prevention interventions. Result include: decreases in use by young people consistent with experimentation and discontinuation, a reduction in drug inducted deaths, and a significantly reduced burden in courts and the prison system.[21]

Recommended action

68. Health care services in criminal justice settings should be equivalent to those available in community settings. Currently there are inequities for prisoners which if addressed would improve prisoner health, public health and reduce offending behaviour.
69. Justice Targets should be added to the Closing the Gap Targets to reduce the over-representation of Aboriginal and Torres Strait Islander peoples' contact with the criminal justice system.
70. Health services for prisoners should be provided by the relevant State or Territory health department, and prisoners should be given the right to access Medicare and the PBS in those instances where certain health services are not provided by the State or Territory.
71. A harm minimisation approach should be incorporated into health policy, services and standards of care in correctional settings. This should include needle and syringe programs, medically assisted treatment of opioid dependence including the provision of naloxone on release from prison, and testing and treatment for STIs and BBVs.
72. The Commonwealth Government should support a national approach to establish minimum standards to protect, promote and maintain the health and well-being of prisoners.

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