Reducing the harm of prison

Dealing with alcohol and other drugs within the prison system

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Overview

The state incurs the responsibility of providing healthcare to all prisoners in Victoria. The prison population is highly disadvantaged and experiences poor health, welfare and educational outcomes. This includes a Hepatitis C infection rate which is more than 40 fold that of the general community. Maintaining the good health of prisoners results in not only better health and welfare outcomes for those prisoners and their families, but for all Victorians. Many measures that enjoy comprehensive evidential support in reducing the harms in prisons have been neglected, with preference often given to less effective but more populist initiatives. Successive governments have consistently avoided evidence based measures which would make significant inroads into addressing prisoner health issues, resulting in policy inertia.

Greater access to prison based (forensic) alcohol and other drug treatment, needle and syringe exchange programs, uncapped access to pharmacotherapy, which should be seamlessly transferrable to community pharmacotherapy providers upon release, and an increase in the provision of Hepatitis C treatment would greatly increase the health of the prison population and have positive run-on effects to the general population. Furthermore, seamless transition to relevant health and welfare services immediately post release must be prioritised to improve the overall wellbeing of prisoners and the community as a whole.

Introduction

The Victorian prison system continues to grow with a report by the Victorian Auditor-General (VAGO 2012, p ix) indicating that, by 2016, the Victorian prison system will not have sufficient capacity to cater for the prison population. The report also found that prison-based incidents (such as self-harm, attempted suicide and assault) have doubled over the past six years and that the provision and resourcing of treatment and rehabilitation programs have not kept pace with prison population growth.

To date, there has been little regard to the known and preventable harms which continue to pervade the prison population. These harms are the result of a range of acute vulnerabilities which are evident with this population and exacerbated by the circumstances of incarceration.

VAADA is particularly concerned that, within a climate of explosive prison population growth and the pending capacity crisis, approximately 70 per cent of prisoners have used illicit drugs in the past 12 months (AIHW 2013, p xii). This issue continues to be sidelined, with a dedicated but significantly under-resourced forensic treatment system servicing the vulnerable population. Also of concern is the indifference from successive governments towards the enduring hepatitis C viral (HCV) epidemic within Victoria's prisons, with the Victorian Ombudsman (2011, p 8) citing that approximately 41 per cent of Victorian prisoners are infected by this preventable and treatable disease compared with one per cent of the general population. Only three of the 14 prisons in Victoria offer HCV treatment

(Ombudsman 2011, p 3). Infection rates are even higher in the female prison population with estimates indicating rates of 50 to 70 per cent (HCV Projections Working Group 2006, p 16). These statistics are indicative of a muted health crisis within the prison system. This information highlights an opportunity for significant health interventions on what is a condensed and captive population. There are, however, a range of issues which need to be considered in weighing up the appropriate response to this challenge.

Finally, although the mortality rate within prisons is high, the post release mortality rate is higher still, with just under half of all Australia-wide ex-prisoner deaths between 2000 – 2007 being attributed to 'accidental drug related deaths' (Andrews and Kinner 2012, p 5) and during 2007-08 it is estimated that 449 recently released prisoners died within one year of release (Kinner et al 2011, p 64). More recently, data from the Coroners Court of Victoria (2013) indicates that between 2000 and 2010, 120 individuals died due to a drug overdose within either two months of exiting prison or whilst still in the care of Corrections Victoria; this is a conservative estimation with the methodology noting the potential inclusion of over 50 additional deaths. These preventable deaths require an immediate and comprehensive response from a range of stakeholders to ensure that a robust non-punitive post release aftercare system is developed to ensure that ex-prisoners have ready access to the range of services required for them to successfully and safely integrate into society. Further research into the drivers of this high mortality rate is required to assist in developing the most effective programmatic responses.

Access to Treatment – the over-burdened and under-resourced forensic AOD treatment system

Prisoners generally require a wide array of health and welfare services to address a range of vulnerabilities. This includes the provision of stable housing upon release as well as employment and education opportunities. Some of the work for these endeavours can be undertaken within the prison environment. The provision of adequate health and welfare services may offer potential benefits post release and continuing care should be prioritised where needed. Access to these programs should not be determined by sentence length or security rating, but by the wellbeing and treatment needs of the prisoner. Prisoners should have ready access to relevant community service providers prior to release (Stoové 2012) and should be afforded long term continuing care where necessary.

Prisoners with AOD issues can experience significant difficulties in integrating into society upon release. The prevalence of prisoners with a history of AOD use and the accompanying health issues highlights the need for broad access to forensic AOD treatment programs. This imbalance between service availability and demand, as noted by the Victorian Auditor-General (2012, p xii, 18) who has asserted that treatment and rehabilitation services in prisons are not on par with prison population growth, will impact upon the health of the prison population and contributes to maintaining the excessive level of recidivism among an already increasing prison population.

Although alcohol is the most prevalent substance in forensic treatment presentations, in 2010 approximately 2,300 presentations were related to heroin (Pollard, Berry, Ross and Kiehne 2011, p 29). This is indicative of a prevailing and consistent risk of HCV infection through intravenous drug use. The overburdening of the system, with the pending capacity crisis will result in a viscious cycle of inadequate access to treatment, leading to an increase in recidivism which puts upward pressure on prison numbers and further reduces access to programmatic support for a range of rehabilitation

services, including AOD treatment. This upward pressure is confirmed through a recidivism rate within two years of release of 85 per cent for ex-prisoners who inject drugs (Stoové 2012). The current policy framework is unlikely to address this crisis, which will see a continued increase in recidivism and therefore the prison population as a whole. This has been the case historically, with the annual level of crime reducing by approximately 50000 offences from 2002 to 2012 while the prison population has increased by over 1500 (approximately 40%) over the same period (Sentencing Advisory Council 2013). The Victorian Auditor-General (2012, p 19) notes that the reduction in prisoner access to support services will increase the risk of reoffending. Additionally, the lack of support to facilitate community integration and the impact of imprisonment on families should be addressed.

The common theme among prisoners is a history of injecting drug use which ensures a high prevalence of blood borne viruses in prison environments. This is exacerbated by the system-imposed limitations on successful harm reduction measures which can prevent infection as well as service limitations in access to forensic programs. This dislodges one of the key levers which can put downward pressure on recidivism rates, the absence of which creates a greater health, welfare and justice burden for the state. In summary:

- All available evidence indicates that there is a high prevalence of blood borne viruses in injecting drug user populations;
- People who use drugs are over represented within our prison system;
- Overcrowding of the prison system increases the prevalence of blood borne viruses and risk of transmission; and
- This risk of transmission further exacerbated by limitations placed on measures that we know through evidence to be successful in reducing transmission rates.

Seamless access to pharmacotherapy upon release and post release AOD treatment programs (where necessary) reduce the likelihood of reoffending, post release overdose and overall AOD use and related harm (Hedrich, Alves, Farrell, Stöver, Moller and Mayet 2012).

Recommendations

1. The Victorian Government provide additional resources to forensic AOD treatment to match the needs of the rapidly growing prison population
2. The Victorian Government enhance existing post release support programs to cater for the range of vulnerabilities recently released prisoners face. This includes health, welfare and education-based arrangements made prior to release (including AOD, housing, community mental health and employment). These programs should be evaluated

Mortality – reducing the post release death toll

Ex-prisoner mortality is exceptionally high with the crude mortality rate for prisoners four weeks following release being 15.3 per 1000 person years and 9.1 per 1000 person years over a 365 day period (AIHW 2013, p 155). A study of Queensland prisoners found that prisoner mortality for those released under the age of 25 years were 6 times greater than their cohorts in the general community; for young women, the mortality rate was 20 times greater. Drugs were the underlying or contributing cause in 43 per cent of young recently released prisoner mortality and half of all recently released young females (Van Dooren, Kinner and Forsyth 2013, pp 379 – 380).

Andrews and Kinner (2012, pp 4 – 5) note that 45 per cent of post release prisoner deaths involved AOD between 2000 and 2007. Of that portion, only 16 per cent were employed and just over one quarter was homeless. These ex-prisoners were unlikely to access generalist medical assistance and more likely to have previously engaged in injecting drug use and previously overdosed. Just under half of the prisoner deaths involving AOD were cited as having previously used heroin and only just over five per cent were engaged in pharmacotherapy (Andrews and Kinner 2012, p 6). Kinner et al (2011, pp 66 – 67) in their study of ex prisoner deaths between 2007-2008, note that the mortality rate is disproportionately high in the first four weeks post release. This is supported by Coronial data (Coroners Court 2013) which notes that 128 individuals died within two months of release from prison or whilst under the care of Corrections due to overdose. This conservative estimate supports the endemic trend of high mortality rates post release and accords with Kinner et al (2011) suggestion of increased access to pharmacotherapy post release as well as trialling the provision of naloxone to high risk ex-prisoners. The latter suggestion is particularly relevant with research indicating that ex-prisoners with a history of drug use, mental illness, poor social supports and nonfatal overdose are at greatest risk of fatal overdose (Kinner 2012). These more vulnerable prisoners are less likely to have strong social resilience and may lack familial support.

Targeted provision of naloxone to supports and family for ex-prisoners broadly fitting into high risk categories would be an effective measure to reduce mortality. Research indicates that in the US, naloxone has reversed more than 10,000 opioid overdoses (ANCD 2012, p 5). Given the high prevalence of drug related mortality in recently released prisoners, the provision of naloxone to family and peers would be recommended. The Victorian Government is open to increasing the availability of naloxone to peers and families of opioid drug users (Department of Health 2013, p 38), but further action is required to ensure that availability of this life saving substance becomes a reality.[1] The provision of sterile equipment is also a necessity. Finally, a comprehensive program of post release support should be enacted beyond the current array of programs, to support newly released prisoners exhibiting high risk characteristics, in integrating back into society. Existing programs are under-resourced and overburdened and require capacity to provide long term intensive support where required. Current programs range from the provision of generic advice to more intensive support for individuals exhibiting specific vulnerabilities; in most cases, these programs have a set duration which does not provide a continuum of care to address the long term and entrenched elements of disadvantage. Further resourcing for programmatic enhancement is necessary to reduce disadvantage and increase positive health and wellbeing outcomes.

Many of these initiatives are not financially burdensome, especially when considered in light of the voluminous security costs of incarceration.

[1] ATODA (2013), the ACT peak body for alcohol and other drug treatment agencies, has developed an online repository which provides an extensive list of published sources supporting the availability of naloxone.

Recommendations

3. The Victorian Government ensure that pharmacotherapy is available to all prisoners requiring this mode of treatment and that those at risk who are departing prison have immediate and seamless access to pharmacotherapy in the community
4. That naloxone be provided to supports (family and friends) of at risk recently released prisoners and should also be provided to at risk prisoners upon release

Morbidity – enduring endemic levels of blood borne viruses

A wide range of adverse social determinants are evident within the prison population, including the high rate of hepatitis C viral (HCV) infection. The Australian Institute of Health and Welfare (AIHW 2013, pp. ix-xv) have indicated that these include:

- low levels of education;
- general poor health, including a high prevalence of mental illness;
- high levels of risky AOD consumption, with 70 per cent of prisoners having used illicit drugs in the past 12 months, compared with 12 per cent of Australians aged 14 years and over who have used illicit drugs (AIHW 2013a);
- Disproportionately high levels of tobacco use with 84 per cent prisoners using tobacco which is well above the national average of 16.4 per cent in 2010) (Cancer Council NSW 2012);
- Likelihood of prior incarceration (including juvenile detention); and
- over-representation of Aboriginal and Torres Strait Islanders (ATSI) (AIHW 2010, pp. ix – xi) with an imprisonment rate of 1607 ATSI prisoners per 100000 head of population in Victoria in 2012 (ABS 2012, p 57).

Forty-four per cent of prisoners in Australia have previously injected drugs (AIHW 2013, pp. xii). This factor, which correlates with the Ombudsman's (2011, p 8) reporting of the high prevalence of HCV infection in prisons (41 per cent), as well as hepatitis B Virus (20 per cent), demonstrates the perpetual ill-health which pervades this population and the durability of this health crisis.

The most prevalent means of transmission of HCV is through intravenous drug use, consisting of 82.3 per cent of cases (HCV Projections Working Group 2006, p. 7). A high proportion of prisoners have both histories of injecting drug use (AIHW 2010, p. 106) and, in many cases, continue to engage in intravenous drug use in prison. For instance, approximately half of the injecting drug users who are imprisoned continue to inject in prison and in NSW, 68 per cent of prisoners continuing to inject drugs did not use sterile equipment (Hepatitis Australia 2011, p. 6). Further to this, an international study asserts that one fifth of prisoners injected drugs for the first time whilst in prison (Stöver and Michels 2010, p. 1).

Prison provides an ideal opportunity to treat HCV, however, only three of Victoria's 14 prisons currently offer treatment (Victorian Ombudsman 2011). Hellard et al (2012, p 639) indicates that treating 25 per 1,000 people who inject drugs and who experience HCV would, over 30 years, reduce the prevalence of infection by 50 per cent. Given the captive nature of prisoners, combined with the high prevalence of HCV and the pending improvements in HCV treatment (including shorter treatment times and a reduction in adverse side-affects), prison would provide the ideal environment to rollout a robust and comprehensive treatment program.

The Australian Institute of Criminology's (AIC) DUMA project (Sweeney and Payne 2012, p 88) indicated that, in a study undertaken at Footscray police station where 333 detainees were surveyed in 2009-10, 77 per cent tested positive for at least one drug and of that subgroup, 51 per cent tested positive for heroin. It is evident that a large portion of prisoners engage in injecting drug use prior to imprisonment, and a significant portion continue to inject utilising paraphernalia which is not sterile whilst in prison. Of note is that approximately 40 per cent (or 112 detainees surveyed) indicated that they were engaged in some form of drug treatment (Sweeney and Payne 2012, p. 89). There is strong evidence supporting the effectiveness of a range of treatment programs to either result in cessation or reduction of AOD use and reducing AOD related harms (Ministerial Council on Drug Strategy 2011, p. 11).

Recommendations

5. The Victorian Government develop a comprehensive program of Hepatitis C treatment throughout the Victorian Prison system and ensure that there is a seamless transition from in-prison treatment to continuing care and treatment post release

Harm reduction – simple, cost effective measures to reduce the harms

The efficacy of increased access to HCV treatment would be greatly enhanced if combined with the provision of sterilised injecting equipment and comprehensive and uncapped access to pharmacotherapy. The provision of treatment may also assist as a deterrent to using AOD in prisons as patients have a personal vested interest in maximising the likelihood of a positive health outcome. The Public Health Association (2011, p 38) offers a range of models which could be considered by government for the provision of sterile injecting equipment. These include the use of vending machines, the exchange of injecting equipment in prison health centres and supervised injecting models. Such measures are evidence informed and have been implemented in a number of regions internationally (Harm Reduction International 2012). Such programs should be implemented throughout the Victorian Prison system; refusal to implement these programs is a derogation of the evidence (Wallace et al 2010, p 133).

A large portion of prisoners have a history of AOD misuse and given this fact, the provision of evidence informed measures to reduce the harms associated with AOD misuse is a logical, practical and cost effective solution to assisting this vulnerable cohort. The urgency in which to rollout the range of initiatives listed above is made more critical by virtue of the capacity crisis reported by the Victorian Auditor-General (2012), as well as general community safety and health concerns.

Recommendations

6. The Victorian Government trial the provision of sterile injecting equipment in Victoria's prison system. This should be undertaken in a manner which does not provide opportunity for discrimination against specific prisoners and maintains the safety of prison staff

Conclusion

This position paper highlights the endemic HCV infection rate with in the Victorian prison system and the lacklustre efforts to date from successive governments to tackle this issue. It provides a range of initiatives to drive down the infection rate and achieve positive health and wellbeing outcomes for both prisoners and the community at large. The paper also highlights the pending capacity crisis identified by the Victorian Auditor-General and demonstrates that this crisis will be intensified unless additional resources are provided for AOD treatment (both forensic and community-based) as well as the role of pharmacotherapy in reducing both illness and crime, as well as enhancing wellbeing.

This paper also relays recent research on post release prisoner mortality and calls for a range of programmatic reforms to provide support to 'at risk' prisoners.

Prisoners continue to be neglected and maligned in most mainstream public discourse. This stigma results in the continuation of harmful policies. These policies continue to engender a disproportionate health and financial cost to the community, and the continued failure of prisons to reduce recidivism will elicit future victims.

VAADA's Recommendations

VAADA proposes the following recommendations:

1. *The Victorian Government provide additional resources to forensic AOD treatment to match the needs of the rapidly growing prison population;*
2. *The Victorian Government enhance existing post release support programs to cater for the range of vulnerabilities recently released prisoners face. This includes health, welfare and education-based arrangements made prior to release (including AOD, housing, community mental health and employment). These programs should be evaluated;*
3. *The Victorian Government ensure that pharmacotherapy is available to all prisoners requiring this mode of treatment and that those at risk who are departing prison have immediate and seamless access to pharmacotherapy in the community;*
4. *That naloxone be provided to supports (family and friends) of at risk recently released prisoners and should also be provided to at risk prisoners upon release;*
5. *The Victorian Government develop a comprehensive program of Hepatitis C treatment throughout the Victorian Prison system and ensure that there is a seamless transition from in prison treatment to continuing care and treatment post release;*
6. *The Victorian Government trial the provision of sterile injecting equipment in Victoria's prison system. This should be undertaken in a manner which does not provide opportunity for discrimination against specific prisoners and maintains the safety of prison staff.*

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Disclaimer

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