THE UNIVERSITY OF MELBOURNE

Addressing inequalities experienced by people released from prison: the role of the AOD service system

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The need for multi-agency care

"Providers and administrators in both the criminal justice system and the community not only share a common set of patients, they also share important public health goals…"

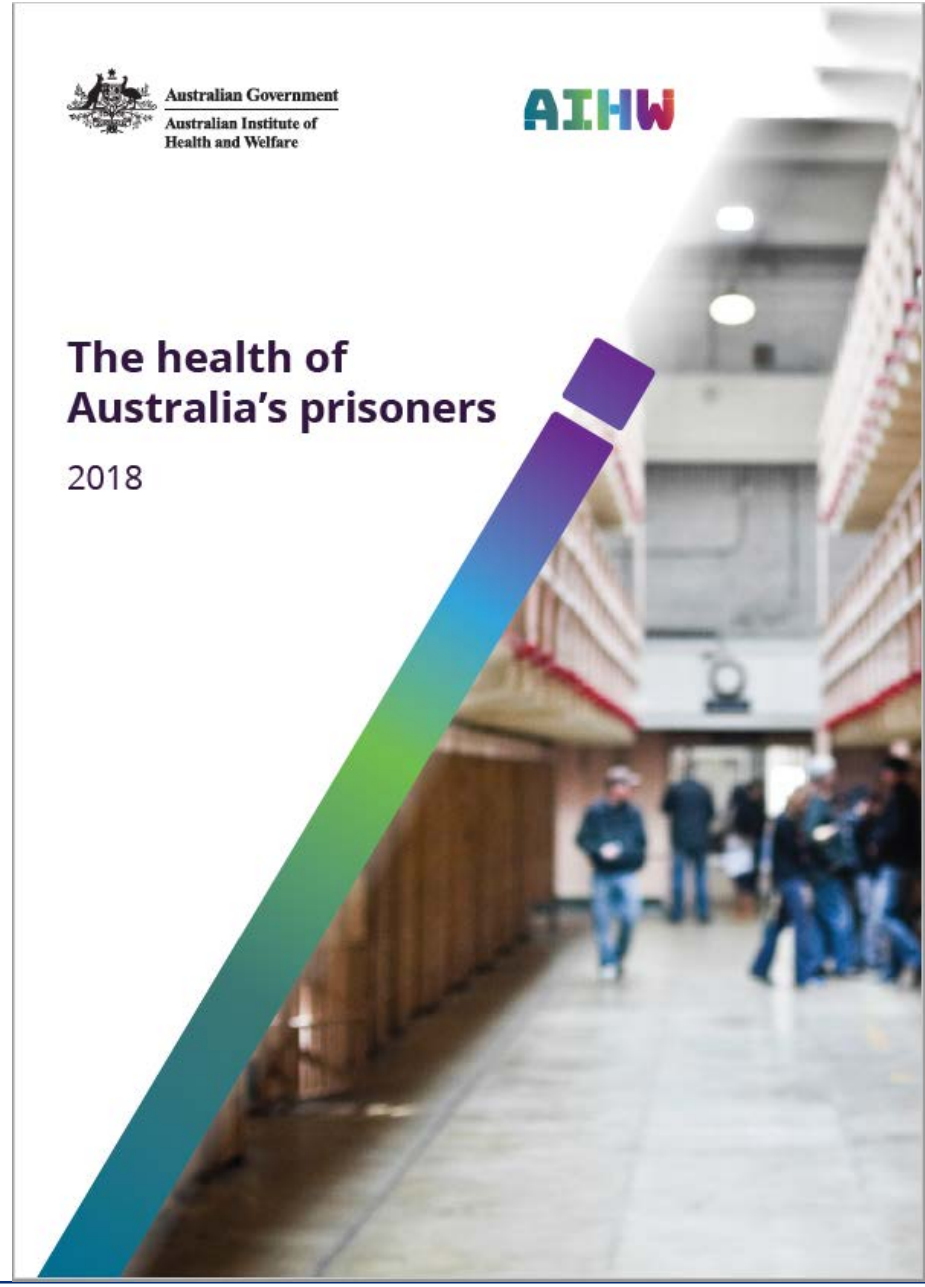
DiPietro and Klingenmaier, 2013 p. e25

DiPietro B, Klingenmaier L. Achieving Public Health Goals Through Medicaid Expansion: Opportunities in Criminal Justice, Homelessness, and Behavioral Health With the Patient Protection and Affordable Care Act. *Am J Public Health.* 2013;103(S2):e25-e29.

People in prison in Australia

Figure 1.1: Trend in Australia's prison population, 2008–2018 (number and rate)

Note: Imprisonment rate is the number of people in prison per 100,000 adults, aged 18 and over, in Australia.
Source: ABS 2018a, Table 2.



Australian Institute of Health and Welfare. The health of Australia's prisoners 2018. Cat. no. PHE 246. Canberra: AIHW, 2019.

In Australia

- Average daily number **42,779**, growing rapidly
  - **~7%** increase annually, **+39%** in the past five years, (community orders **+32%**)
  - Females in prison increasing by >**13% annually**
- Until Apr 2016 'flow' unknown, in 2017 estimated at **63,612 releases**
- Exposure to incarceration: **Est. >385,000 (2.5%)** Australian adults
- Real recurrent expenditure on Australian prisons **>$4 billion per annum**
  - Excludes healthcare costs in most jurisdictions
- Daily cost per adult in prison **exceeds** the average daily wage **by a factor of >2**

ABS. (2019) Corrective Services, Australia, December quarter 2018. Canberra: Australian Bureau of Statistics.
ABS. *Average Weekly Earnings, Australia, May 2016.* Canberra2016.
SCRGSP (Steering Committee for the Review of Government Service Provision). *Report on Government Services 2017, vol. C, Justice.* Canberra: Productivity Commission;2017
AIHW. The health of Australia's prisoners 2015. Canberra: Australian Institute of Health and Welfare; 2015. Contract No.: Cat. no. PHE 207.
AIHW. National Survey of Mental Health and Wellbeing: Summary of Results. No. 4326.0. Canberra: AIHW; 2007.

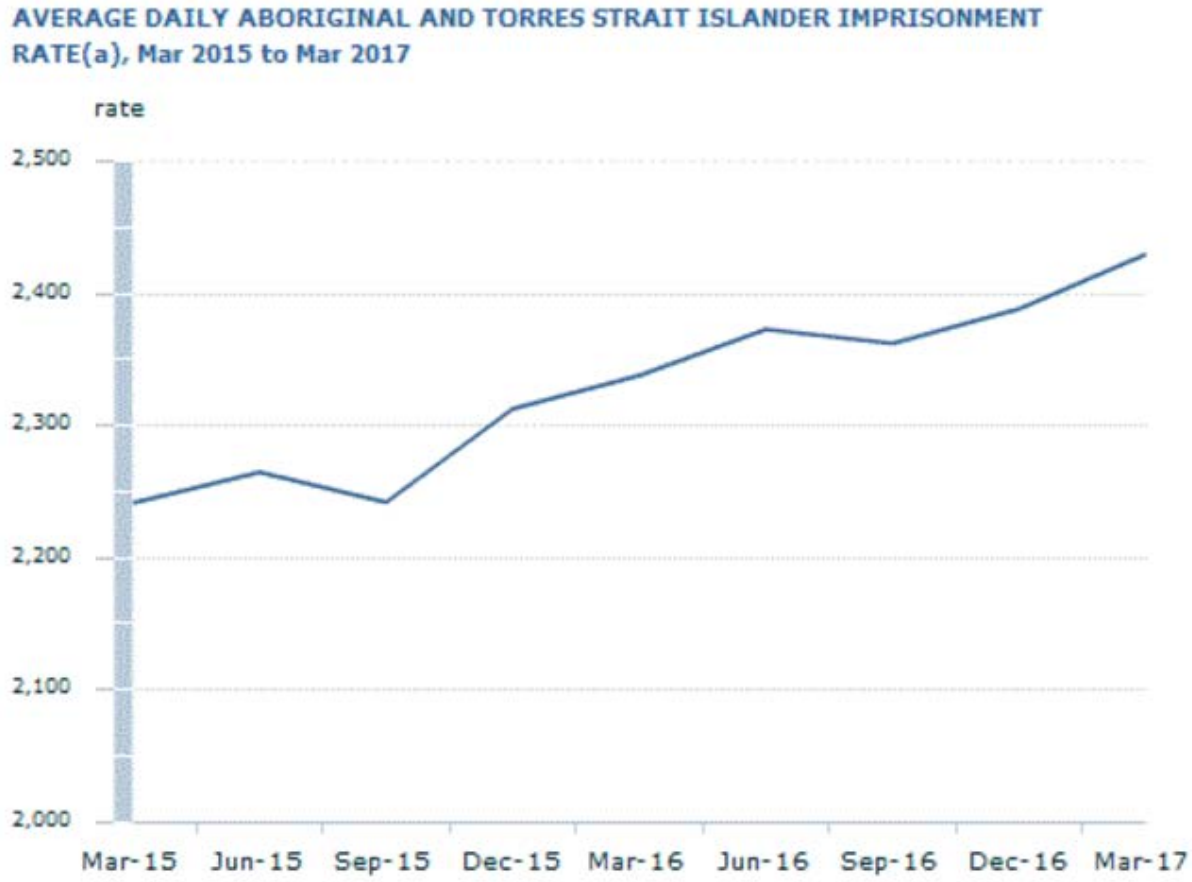
Indigenous over-representation

- Indigenous Australians are over-represented in prison by an **age-adjusted factor of 13**

- **50% increase** in this inequality since 2001

Australian incarceration rate:

215 persons per 100,000 adult population



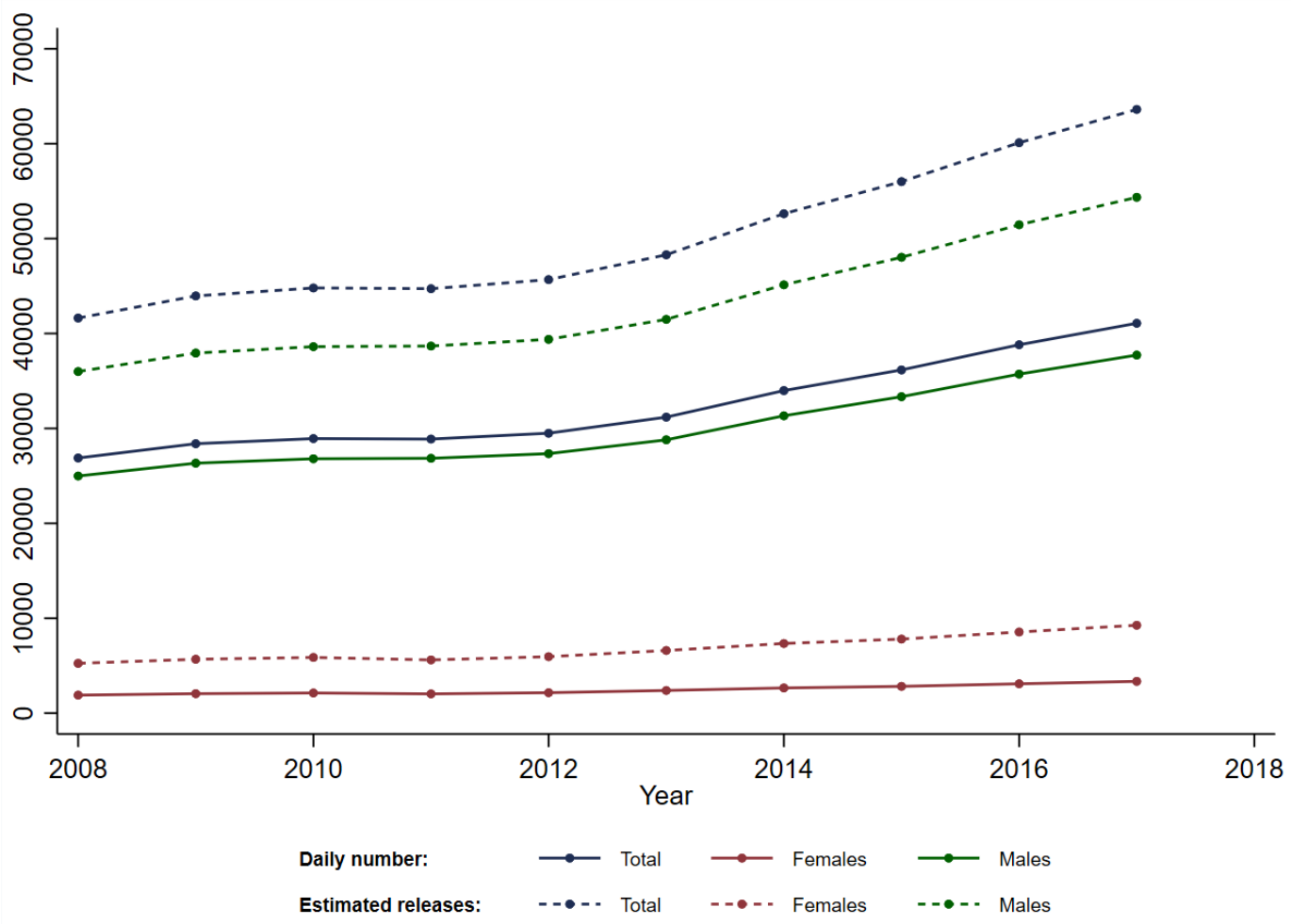
ABS. Corrective Services, Australia, March quarter 2017. Canberra: Australian Bureau of Statistics; 2017. Report No.: cat. no. 4512.0.

Daily average number versus prison throughput

In Australia:

- Increased prison releases
- Overall: **+55%**
- Males: **+44%**
- Females: **+176%**

For other characteristics - **unknown**



Adapted from: ABS. Corrective Services, Australia, June quarter 2018. Canberra: Australian Bureau of Statistics, 2018.
UNODC. Prevention of spread of HIV amongst vulnerable groups in South Asia. New Delhi: United Nations Office on Drugs and Crime, Regional Office for South Asia; 2008.

Trenčín statement on prisons and mental health

Without the integration of community care facilities, continuity of care and alternatives to prison, ***"…attempts to provide good health care in prisons, and especially good mental health care, will almost certainly fail."*** p.6.

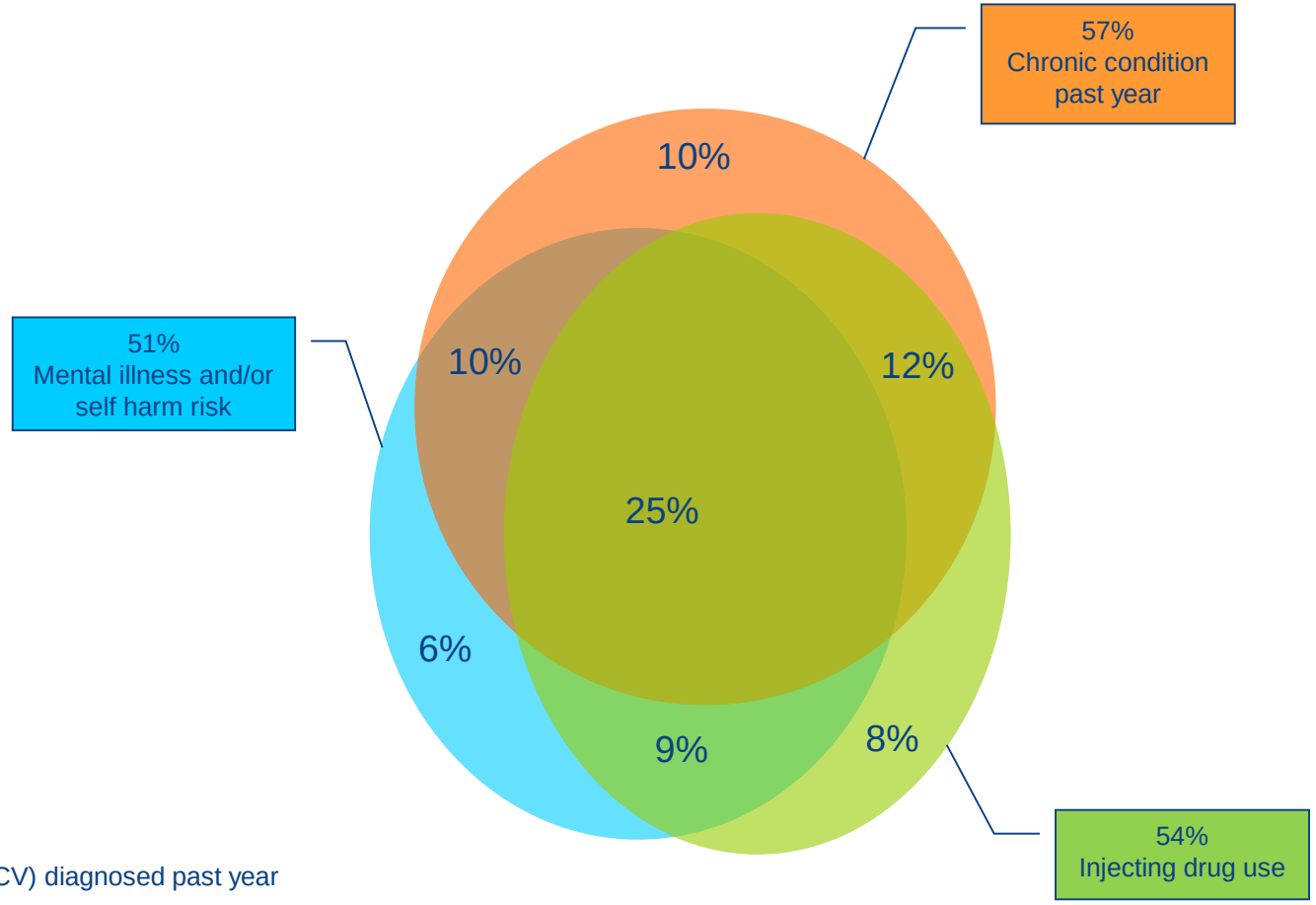
Prevalence of mental health disorders

- Mental health disorders are substantially overrepresented among people in prison
  - Mental illness (MI)
    - Psychosis **(3.6%);** major depression **(10-14%);** personality disorders **(43-65%)**
      - 12-month prevalence in Australia – **80%**
  - Substance use disorder (SUD)
    - Alcohol (**10 - 51%**); Drugs **(22 - 69%)**
  - Dual diagnosis of MI + SUD - **29%** (12-month prevalence)
  - Intellectual disability – **9-11%** screen positive
- All 3 to 11 times higher compared to the general population

Butler T, Indig D, Allnutt S, Mamoon H. Co-occurring mental illness and substance use disorder among Australian prisoners. Drug Alcohol Rev. 2011; 30(2): 188-94
Butler T, Andrews G, Allnutt S, Sakashita C, Smith NE, Basson J. Mental Disorders in Australian Prisoners: a Comparison with a Community Sample. Australian and New Zealand Journal of Psychiatry. 2006;40(3):272-6.

Fazel S, Yoon IA, Hayes AJ. Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. Addiction. 2017.
Fazel S, Danesh J. Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. The Lancet. 2002;359(9306):545-50.
Søndenaa E, Rasmussen K, Palmstierna T, Nøttestad J. The prevalence and nature of intellectual disability in Norwegian prisons. J Intellect Disabil Res 2008; 52(12): 1129-37.
Dias S, Ware RS, Kinner SA, Lennox NG. Co-occurring mental disorder and intellectual disability in a large sample of Australian prisoners. Aust N Z J Psychiatry 2013; 47(10): 938-44.

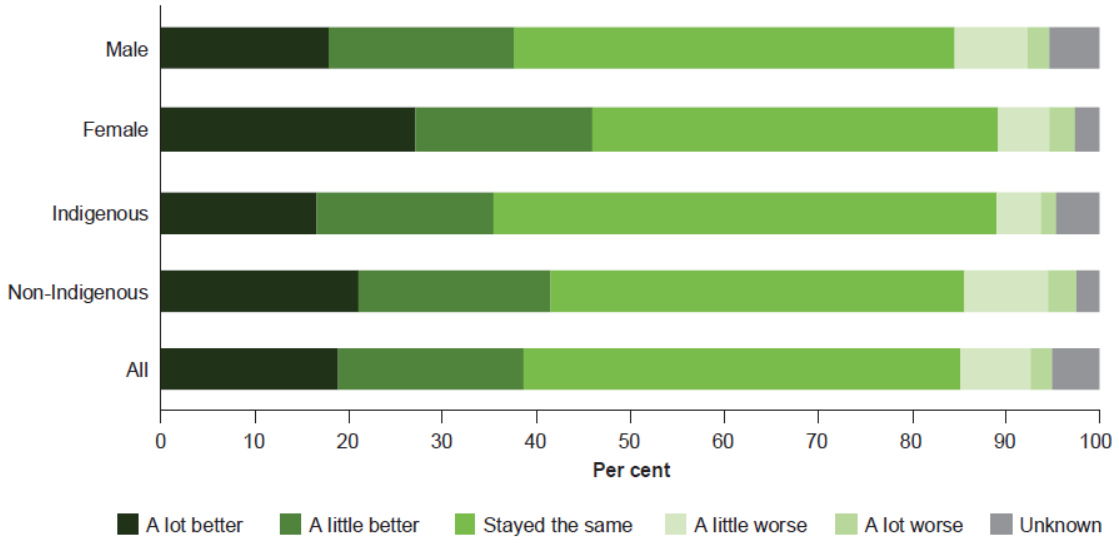
Complex health needs are normative



van Dooren, K., Kinner, S. A. & Richards, A. (2013). Complex health-related needs among young, soon-to-be released prisoners. *Health and Justice, 1:1*.

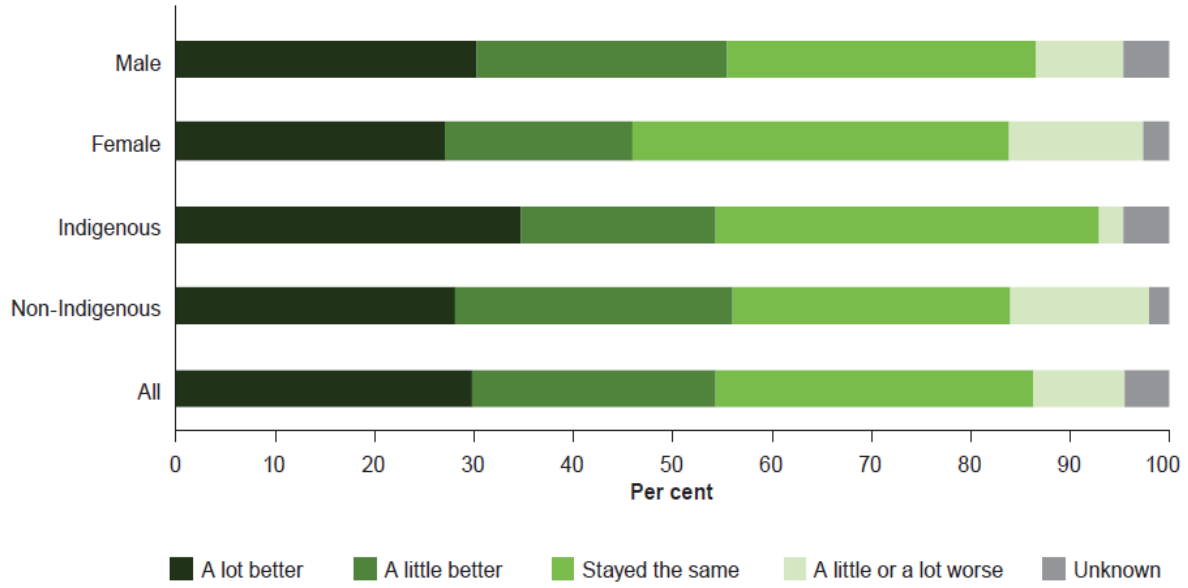
Health often improves in prison

Figure 3.7: Prison dischargees, self-assessed change in mental health and well-being during incarceration, by sex and Indigenous status, 2018 (%)



Notes
1. Proportions are proportions in this data collection only, and not the entire prison population.
2. Excludes New South Wales, which did not provide data for this item.
Source: Dischargees form, 2018 NPHDC.

Figure 7.5: Prison dischargees, self-assessed change in physical health status in prison, by sex and Indigenous status, 2018 (%)



Notes
1. Proportions are proportions in this data collection only, and not the entire prison population.
2. Excludes New South Wales, which did not provide data for this item.
Source: Dischargees form, 2018 NPHDC.

85% and **86%** of dischargees reported their mental and physical health improved or stayed the same, respectively.

Incarceration is health depleting

- Despite any health gains achieved in prison
- Without **sustained care and support** after release, the net effect of incarceration is health depleting
- Increased mortality in people released from prison

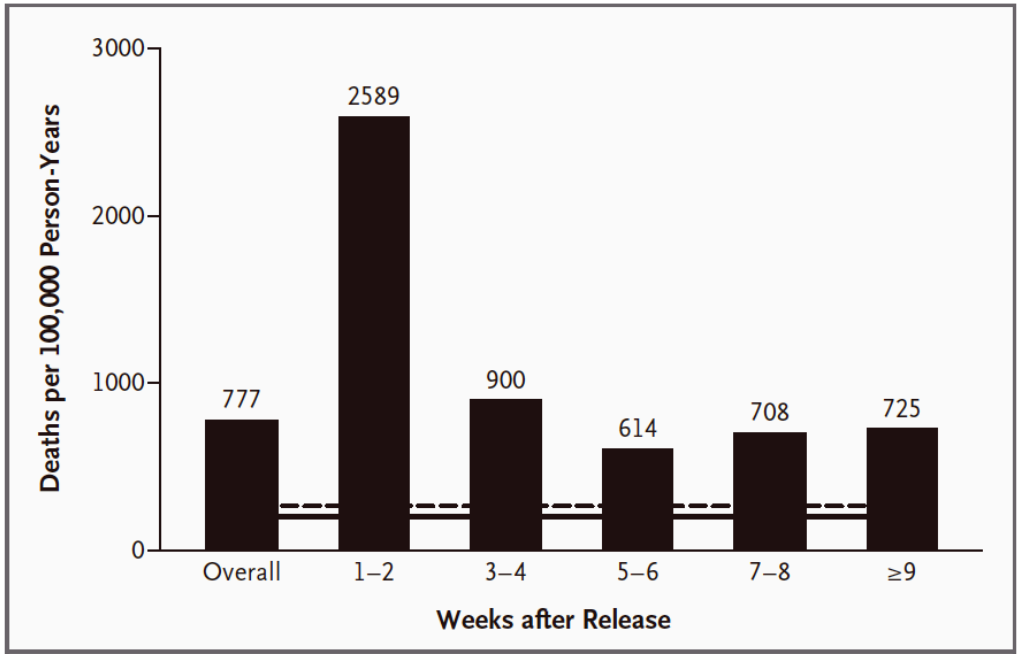


Figure 1. Mortality Rates among Former Inmates of the Washington State Department of Corrections during the Study Follow-up (Overall) and According to 2-Week Periods after Release from Prison.

The dashed line represents the adjusted mortality rate for residents of the State of Washington (223 deaths per 100,000 person-years), and the solid line represents the crude mortality rate among inmates of the state prison system during incarceration (201 deaths per 100,000 inmate person-years).

Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, et al. Release from Prison — A High Risk of Death for Former Inmates. N Engl J Med. 2007;356(2):157-65.

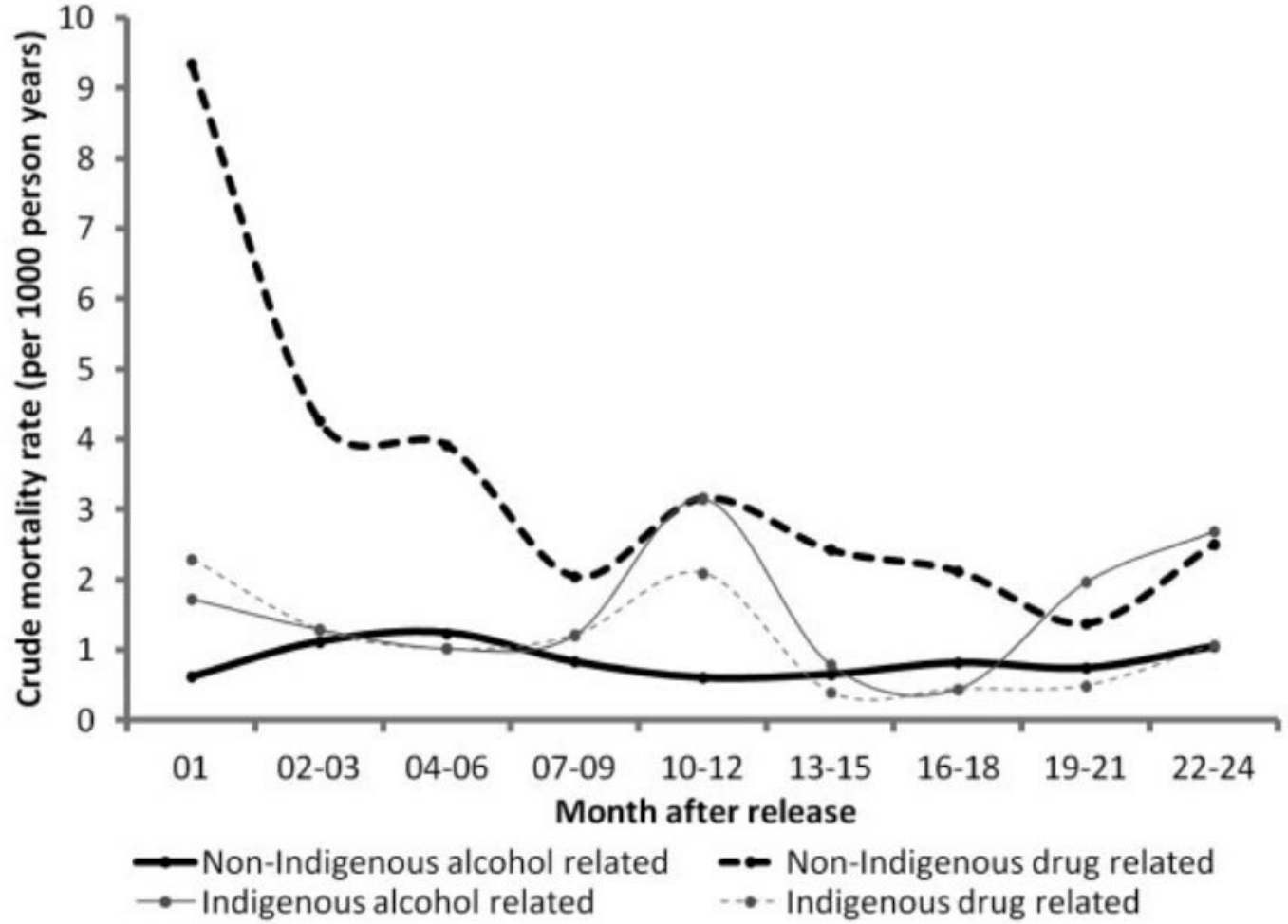
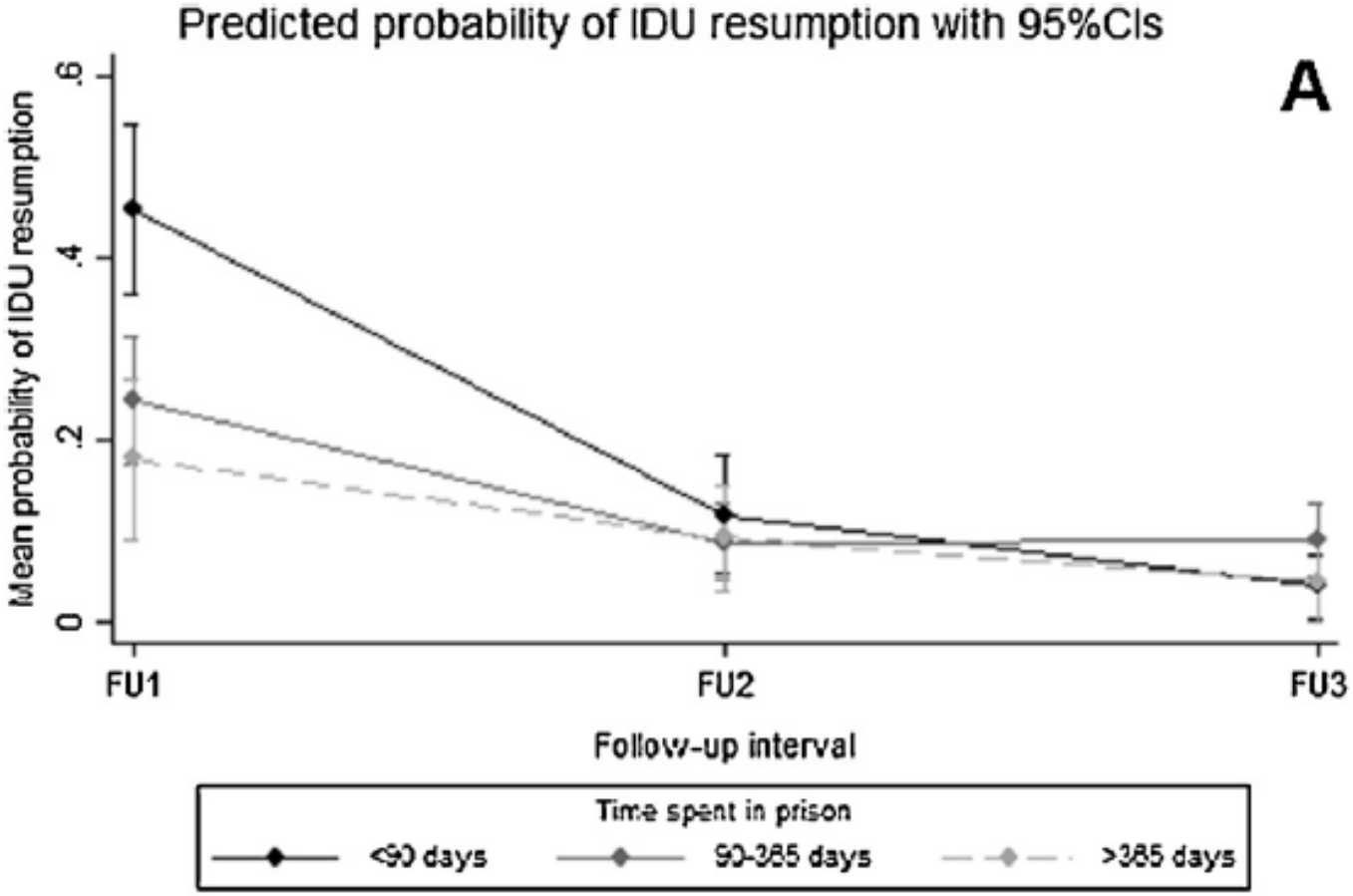


Figure 1 Crude mortality rates after release from prison, by Indigenous status and substance-related cause

Forsyth SJ, Alati R, Ober C, et al. (2014) Striking subgroup differences in substance-related mortality after release from prison. *Addiction* 109(10): 1676-1683.

Prison: only a brief interruption to harmful use

- **23%** of people released with a history of IDU resumed injecting in the first month of release
- **40%** within approx. 6 months
- Those released from short sentences at highest risk



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.

Non-fatal injury after release from prison

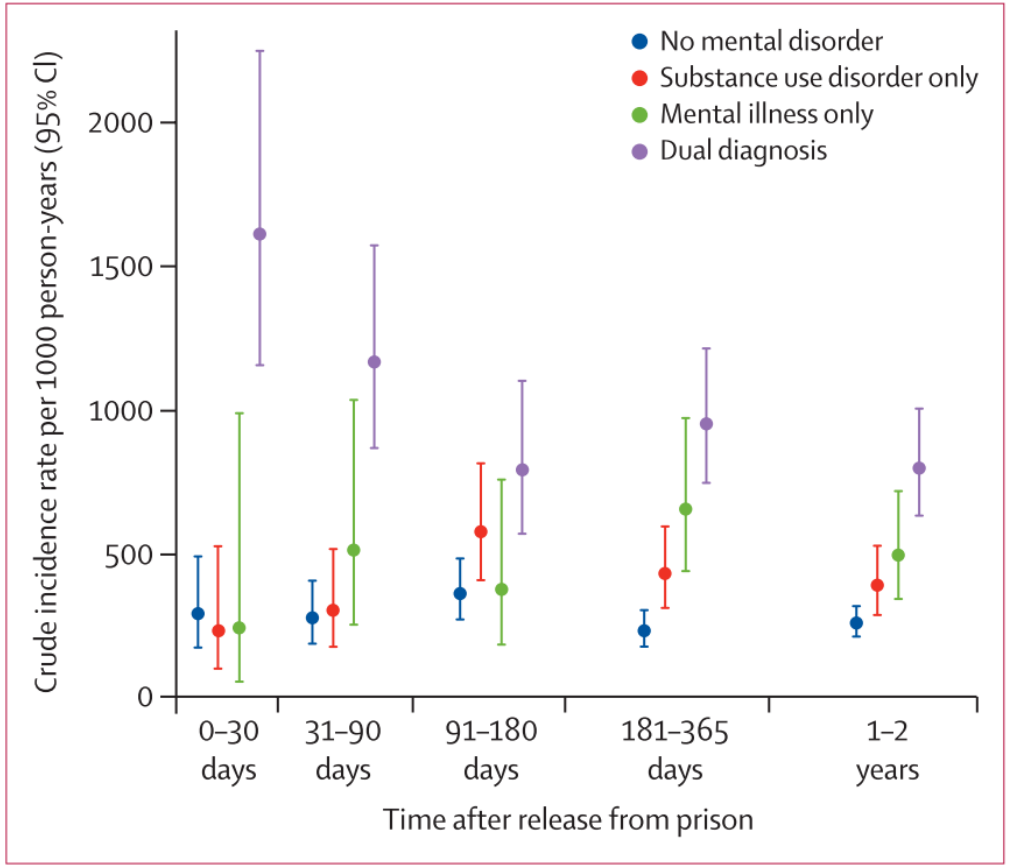


Figure 1: **Piecewise incidence rate of injury within 2 years of release from prison by mental health exposure group**

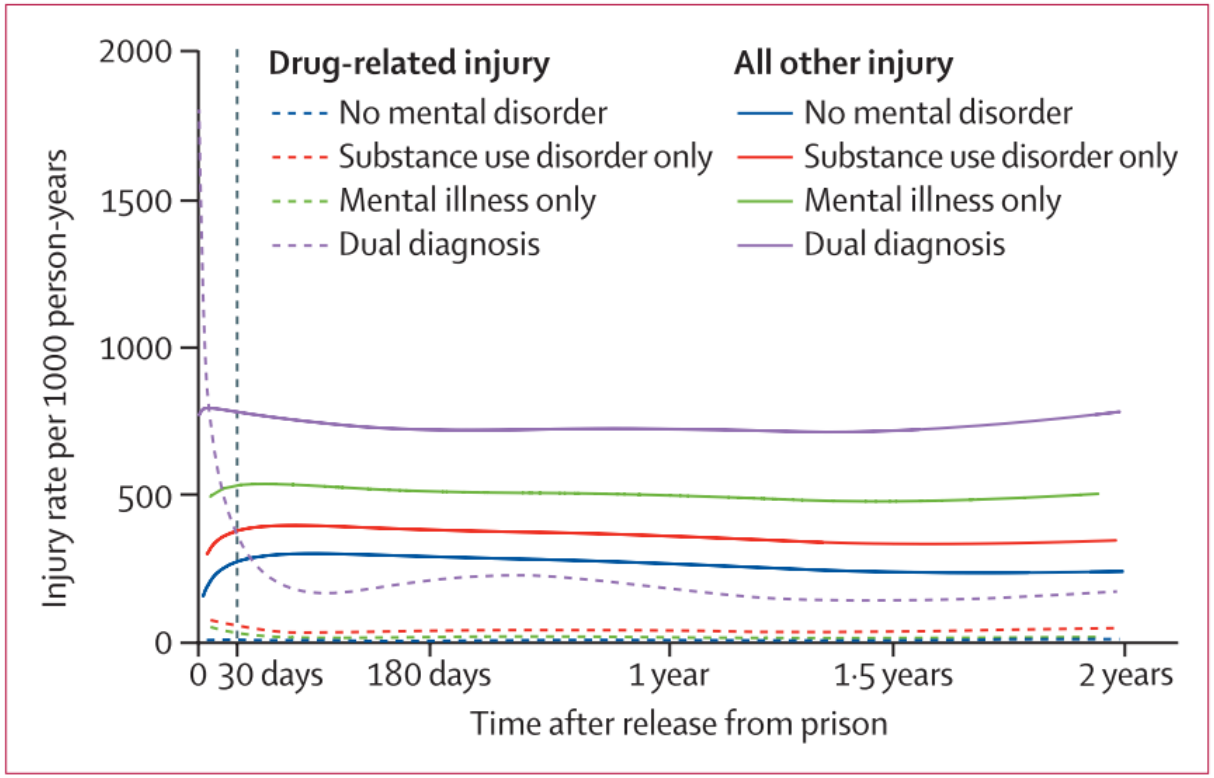


Figure 2: **Predicted injury rate per 1000 person-years after release from prison, according to type of injury (drug-related *vs* all other) and mental health exposure group**

Young JT, Heffernan E, Borschmann R, et al. Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study. *The Lancet Public Health* 2018; 3(5): e237-48.

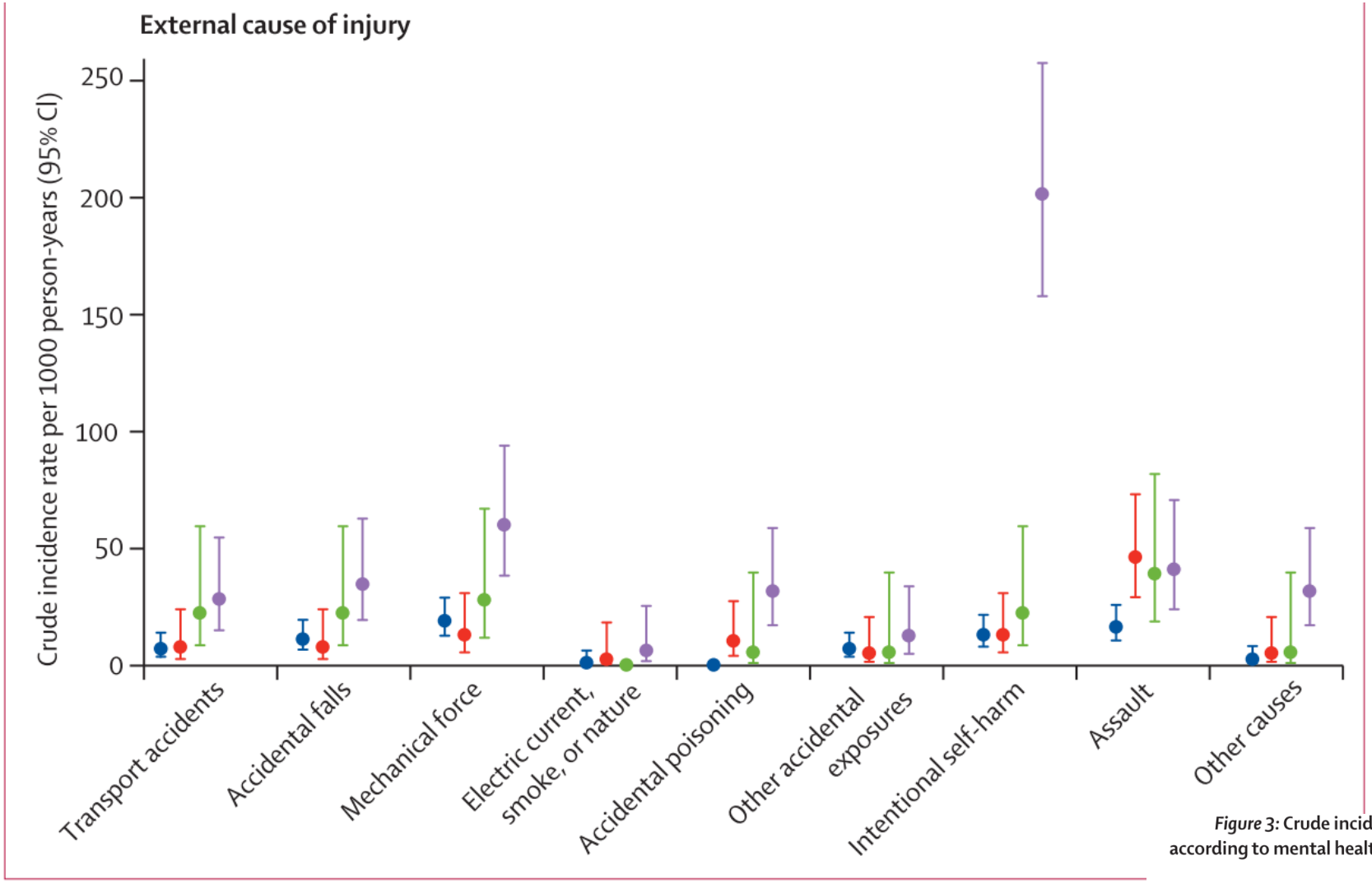


Figure 3: **Crude incidence rates of injury resulting in hospital contact according to mental health exposure group, and by body region of injury, nature of injury, and external cause of injury**

*Includes injuries due to frostbite, radiation, burns due to heat and light, hypothermia, effects of air or water pressure, asphyxiation, effects of deprivation such as hunger or thirst, maltreatment syndromes, and other external causes such as lightning, electric current, non-fatal submersion, and effects of vibration.

EUROPE

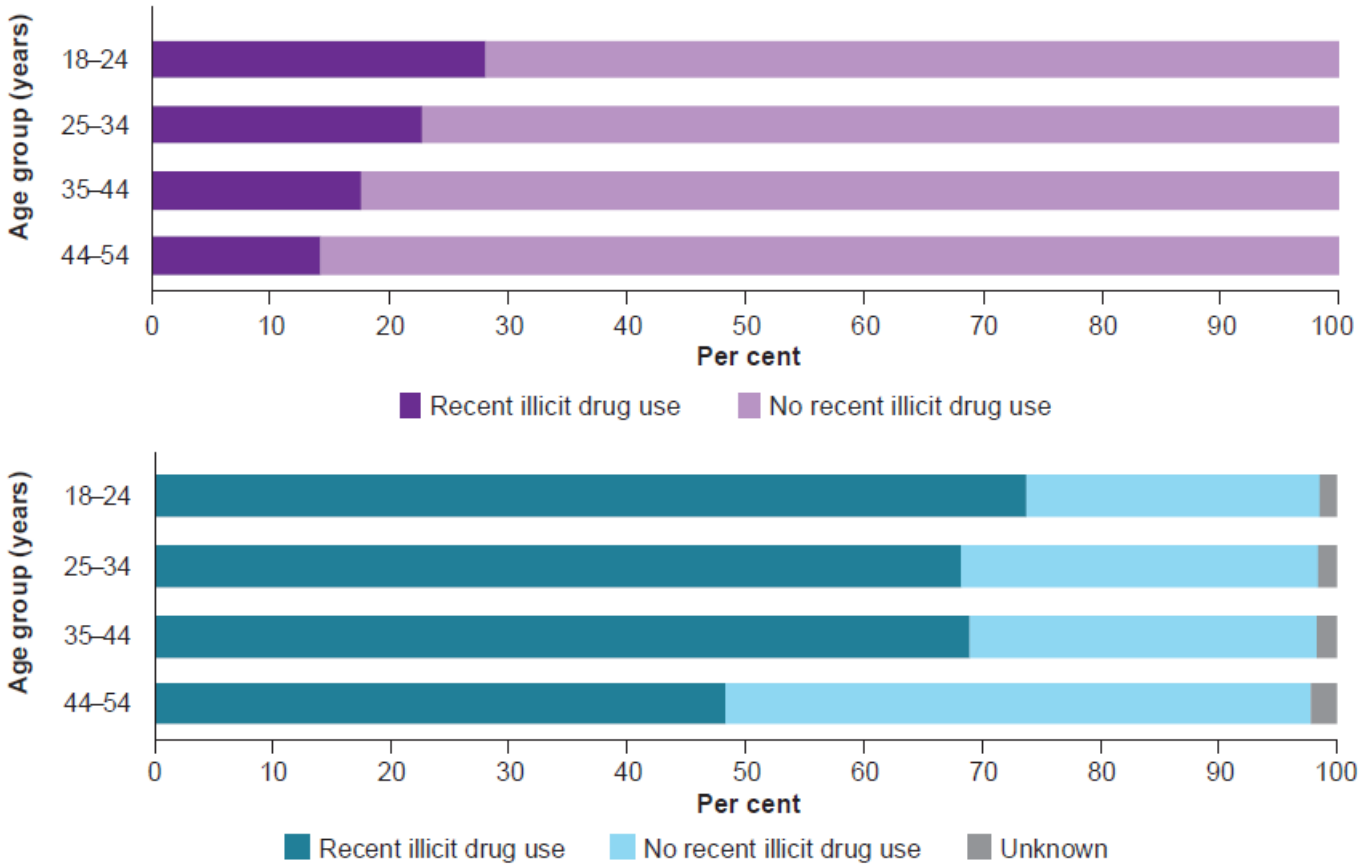
Declaration
Moscow, 24 October 2003

Prison Health as part of Public Health

"…penitentiary health must be an integral part of the public health system of any country… it is necessary for both prison health and public health to bear equal responsibility for health in prisons." p.2.

WHO Europe. Declaration on prison health as public health. Moscow: World Health Organisation Europe, 2003.

Figure 11.6: General community (2016) and prison entrants (2018), illicit drug use in the previous 12 months, by age (%)

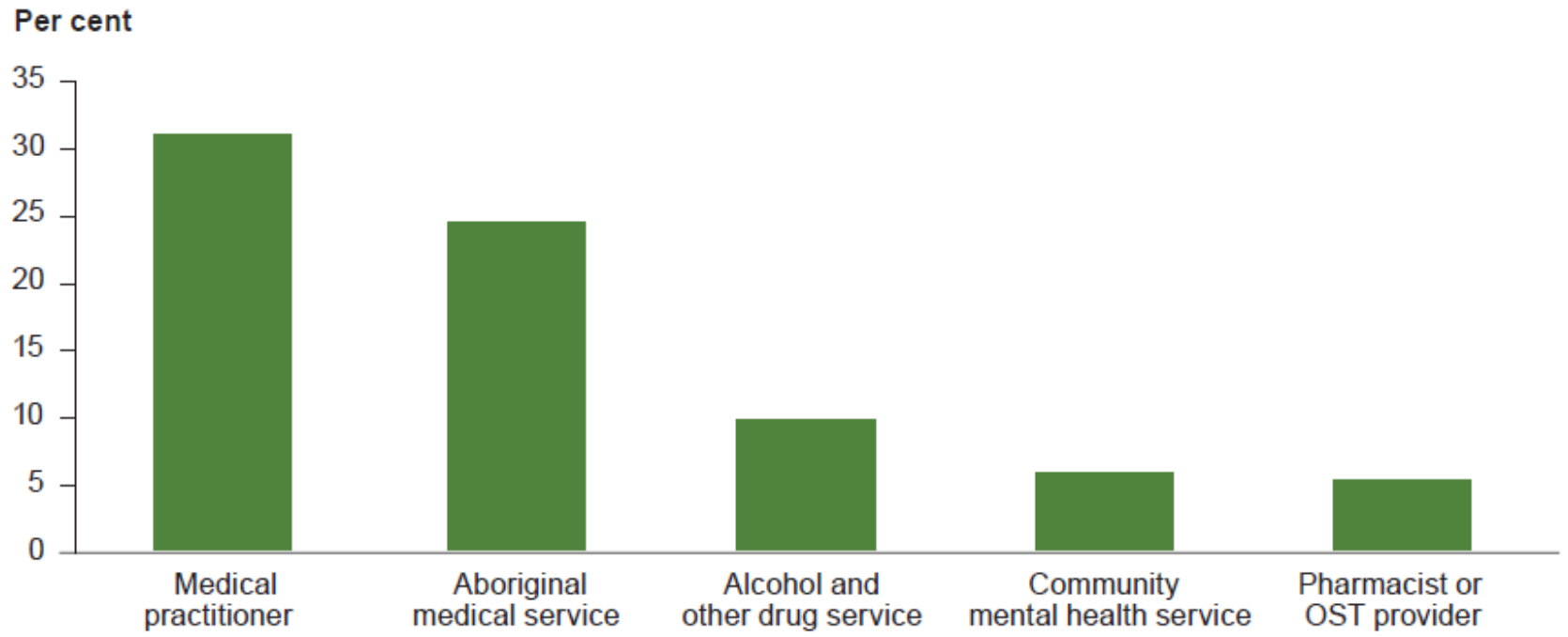


Notes

1. Proportions of prison entrants are proportions in this data collection only, and not the entire prison population.
2. Prison entrants data excludes New South Wales, which did not provide data for this item.

Sources: Entrants form, 2018 NPHDC; AIHW 2017c.

Figure 18.2: Prison dischargees, self-reported referral or appointment to see a health professional after release, by type of health professional or service, 2018 (%)



Notes

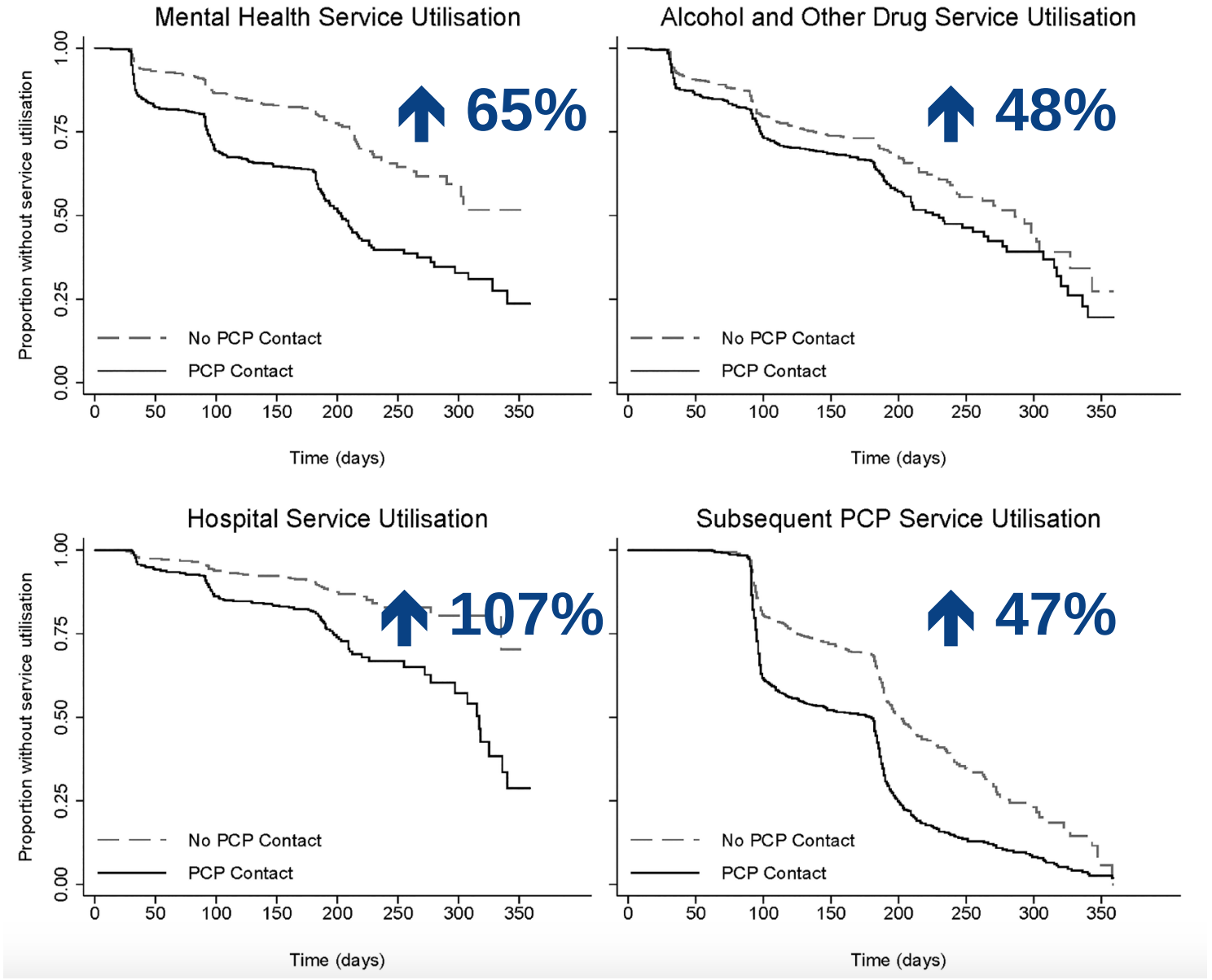
1. Referrals and appointments to an Aboriginal medical service were a proportion of Indigenous dischargees only.
2. OST refers to Opioid Substitution Therapy.
3. Multiple options could be selected.
4. Proportions are proportions in this data collection only, and not the entire prison population.
5. Excludes New South Wales, which did not provide data for this item.

Source: Dischargees form, 2018 NPHDC.

Australian Institute of Health and Welfare. The health of Australia's prisoners 2018. Cat. no. PHE 246. Canberra: AIHW, 2019.

Early primary care contact increases health service engagement

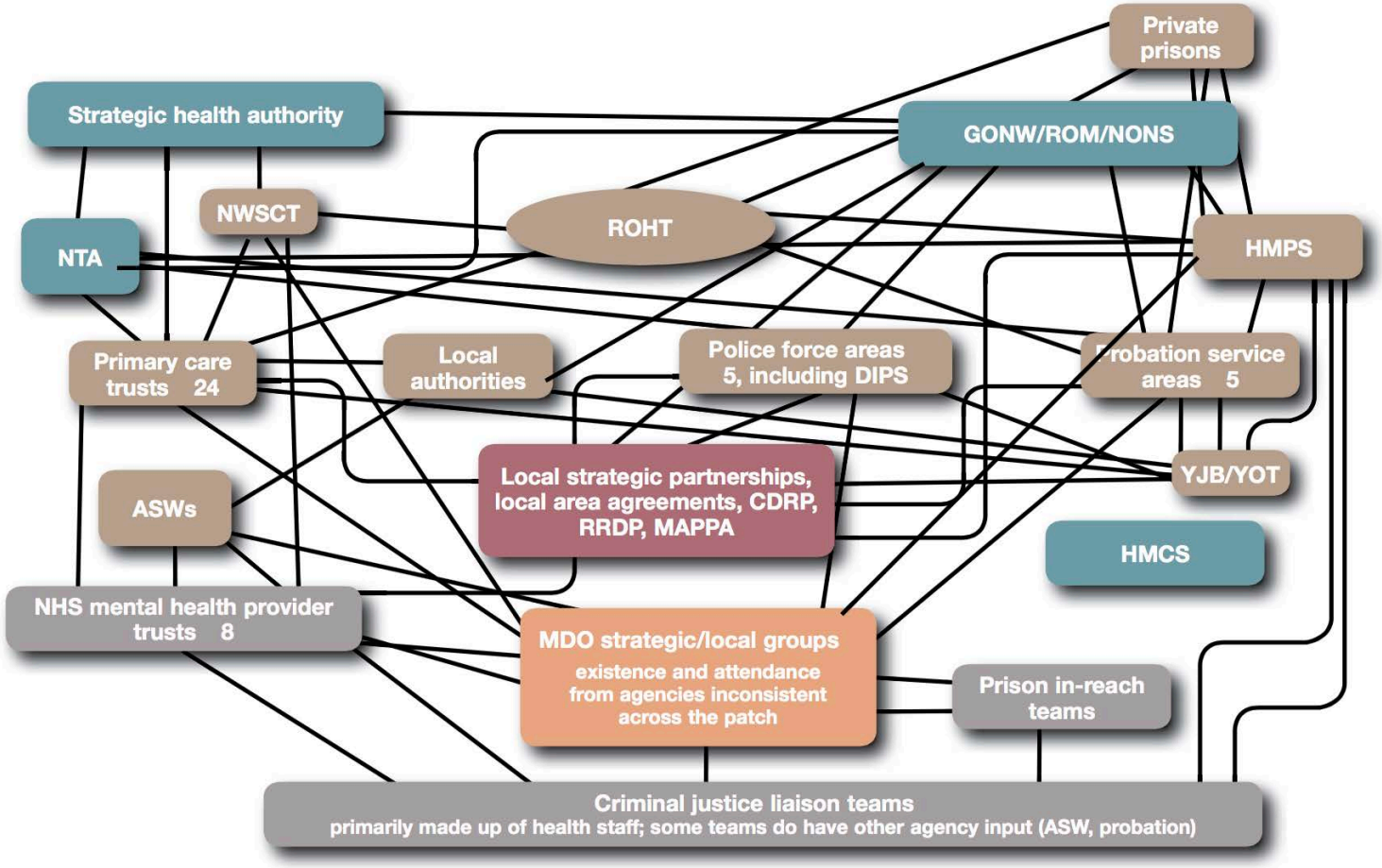
Case management and referral



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(e008021):1-11.

Complex needs, not complex service response

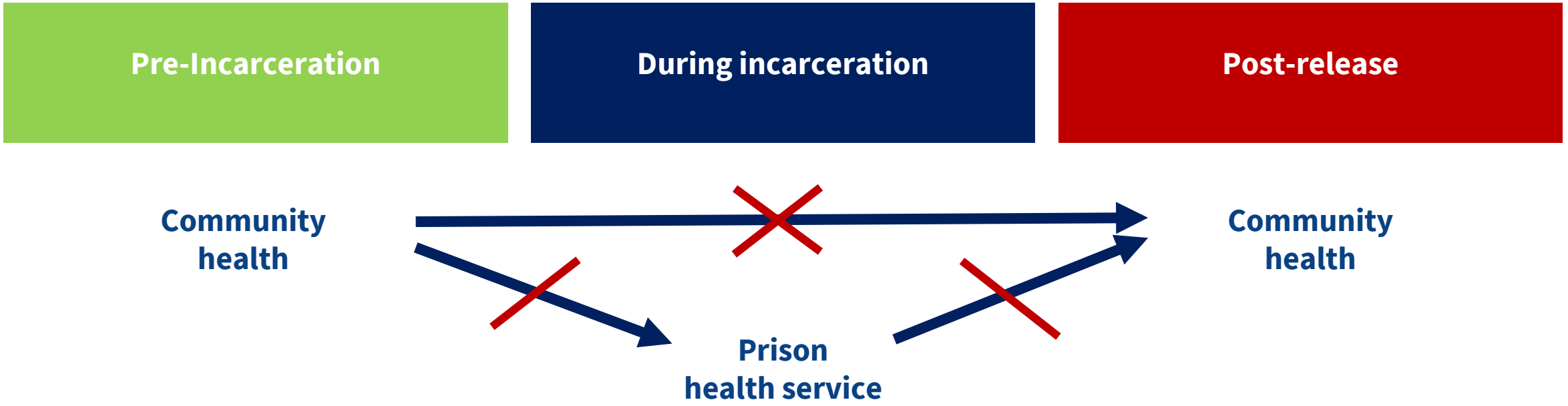
- We cannot treat complexity with complexity
- Strive for integrated (elegant) solutions
- Poor user engagement is a **failure of the service or system meant to respond to their needs**, not a failure of the user



Bradley KJCB. The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London: Department of Health; 2009.

Discontinuity of information

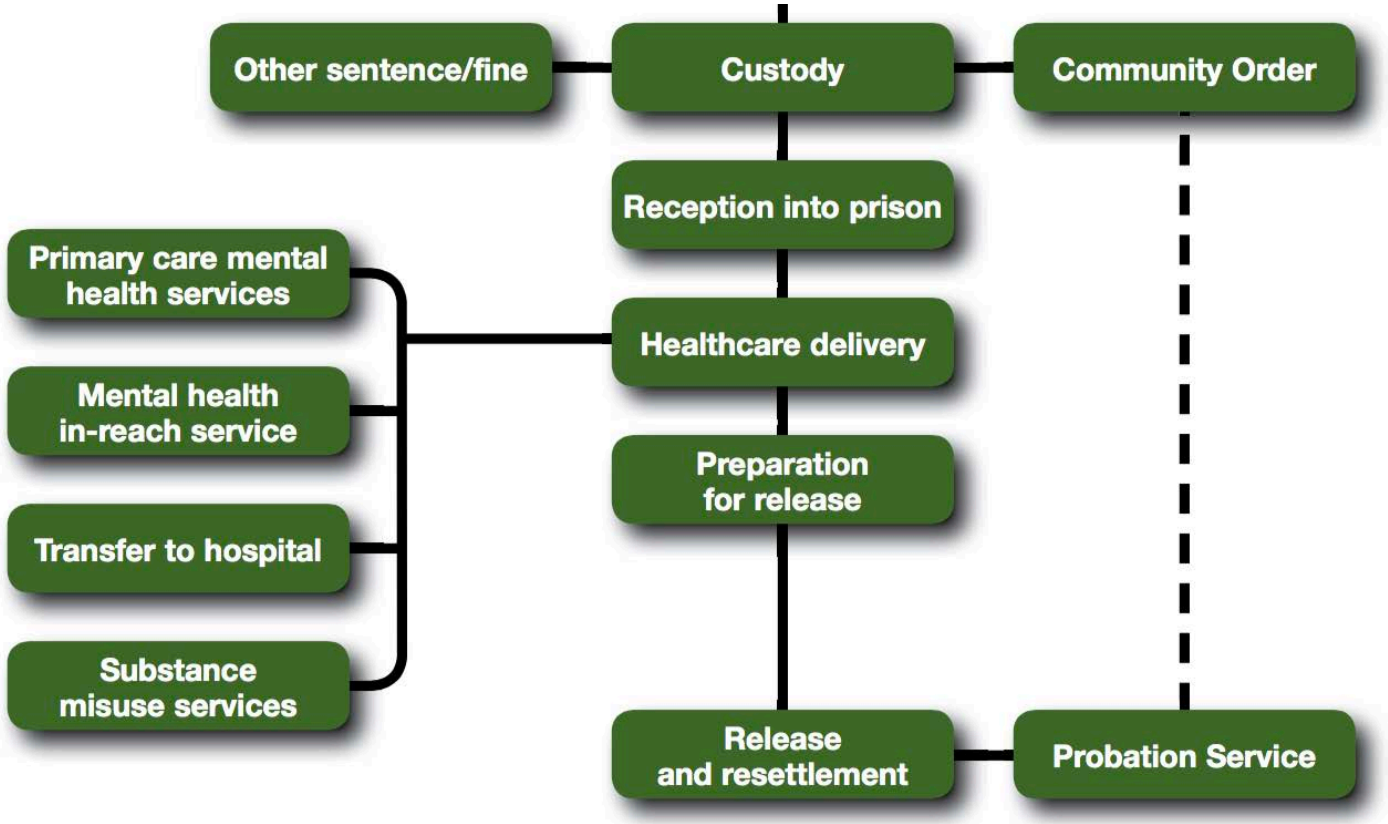
- There is often discontinuity in the flow of information



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;41:268-76.

Discontinuity of information

- Timely information is critical for continuity of care



> **Correct decision-making for the service user can only take place if the decision maker is in receipt of full information concerning the subject.**

Commander Rod Jarman, then ACPO Mental Health and Disability Lead, 28 February 2008

Bradley KJCB. The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London: Department of Health; 2009.

Discontinuity of information

- Systematic gathering and improved flow of health information is crucial for prevention/intervention
  a) Community → Prison → Community
- For the vast majority - ad hoc, no clearly defined health information/referral protocol for transition
- Prerequisite for needs assessment, understanding and evaluating equity and continuity of care
- Clinicians, support workers, and service providers will not act on information they do not have

Discontinuity of care pervades

- In practice
  - A lack of systematic screening/identification
    - Precludes people with mental illness, substance use disorder, and/or cognitive disability from services commensurate to their needs
  - Transitional planning is limited and often ‘ad-hoc’
    - People serving short sentences are not eligible
    - Early planning is rare
    - If release is not planned, medical discharge summary often not generated
  - Often no formal referral procedure between correctional and health providers
    - In-reach is scarce and little knowledge of community service providers

Young JT, van Dooren K, Claudio F, Cumming C, Lennox N. Transition from prison for people with intellectual disability: A qualitative study of service professionals. Trends & issues in crime and criminal justice. 2016;no. 528:1-12.
AIHW. The health of Australia's prisoners 2015. Canberra: Australian Institute of Health and Welfare; 2015. Contract No.: Cat. no. PHE 207.

Remove barriers to continuity of care/information

- Despite Australia's 'no wrong door' policy, still limited integrated care
  - We cannot expect a person with complex needs to navigate a complex system
  - Nor can we expect a health professional to act on information they don't have
  - Service integration and sharing information is critical for success
    - AOD and MH services
    - Prison to community
    - Acute to secondary to tertiary services
  - Clear case to remove the exclusions from Medicare, PBS, the NDIS?
  - Are health services in prison best provided by the Department of Health?

World Health Organization. Health in prisons: a WHO guide to the essentials in prison health. Geneva: WHO, 2007.

Integrated and collaborative efforts

- Not a criticism of correctional/forensic service providers
  - To correct this is an impossible task for one department
- Whole-of-government problem requiring a whole-of-government solution
- This requires a collaborative effort to share knowledge and avoid duplicating efforts
  - Inter-department
  - Inter-state
  - Internationally

The cost of inaction

- Incarceration impacts life expectancy disproportionately across the social gradient
  - In the bottom income quartile:
    - Every additional person in prison per 1000 residents reduces life expectancy by **6 months**

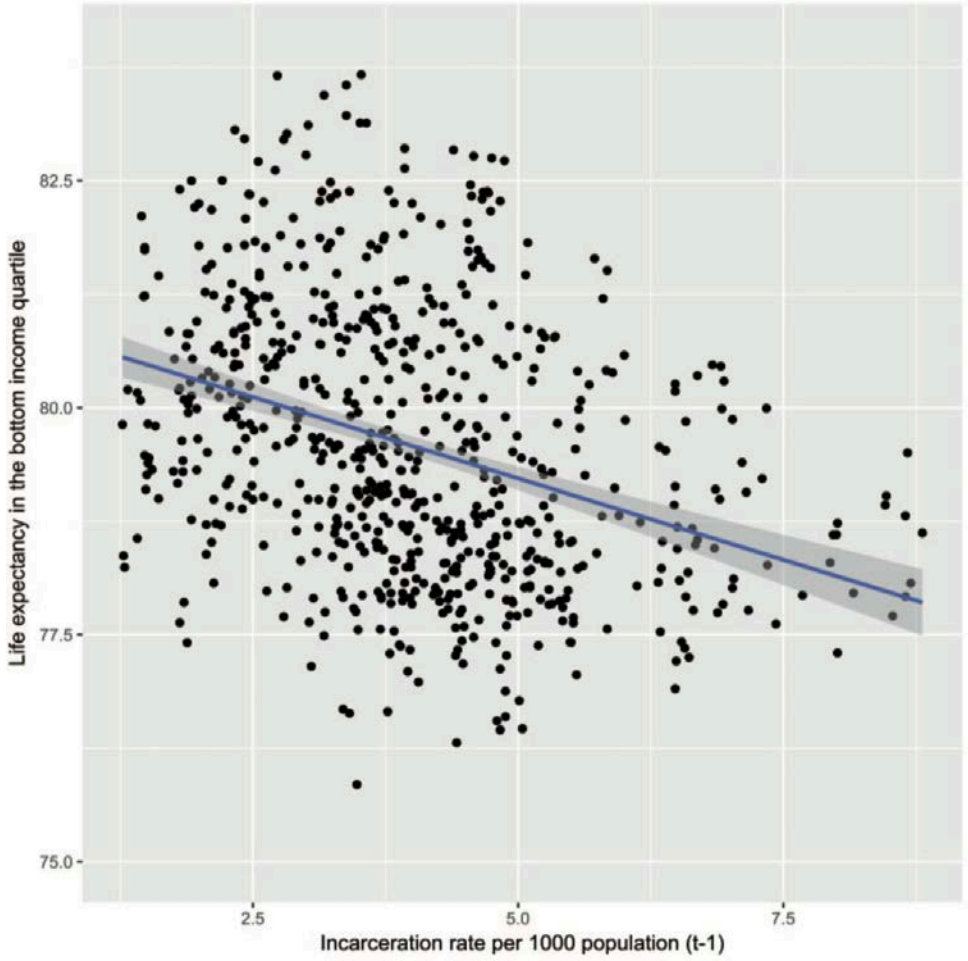


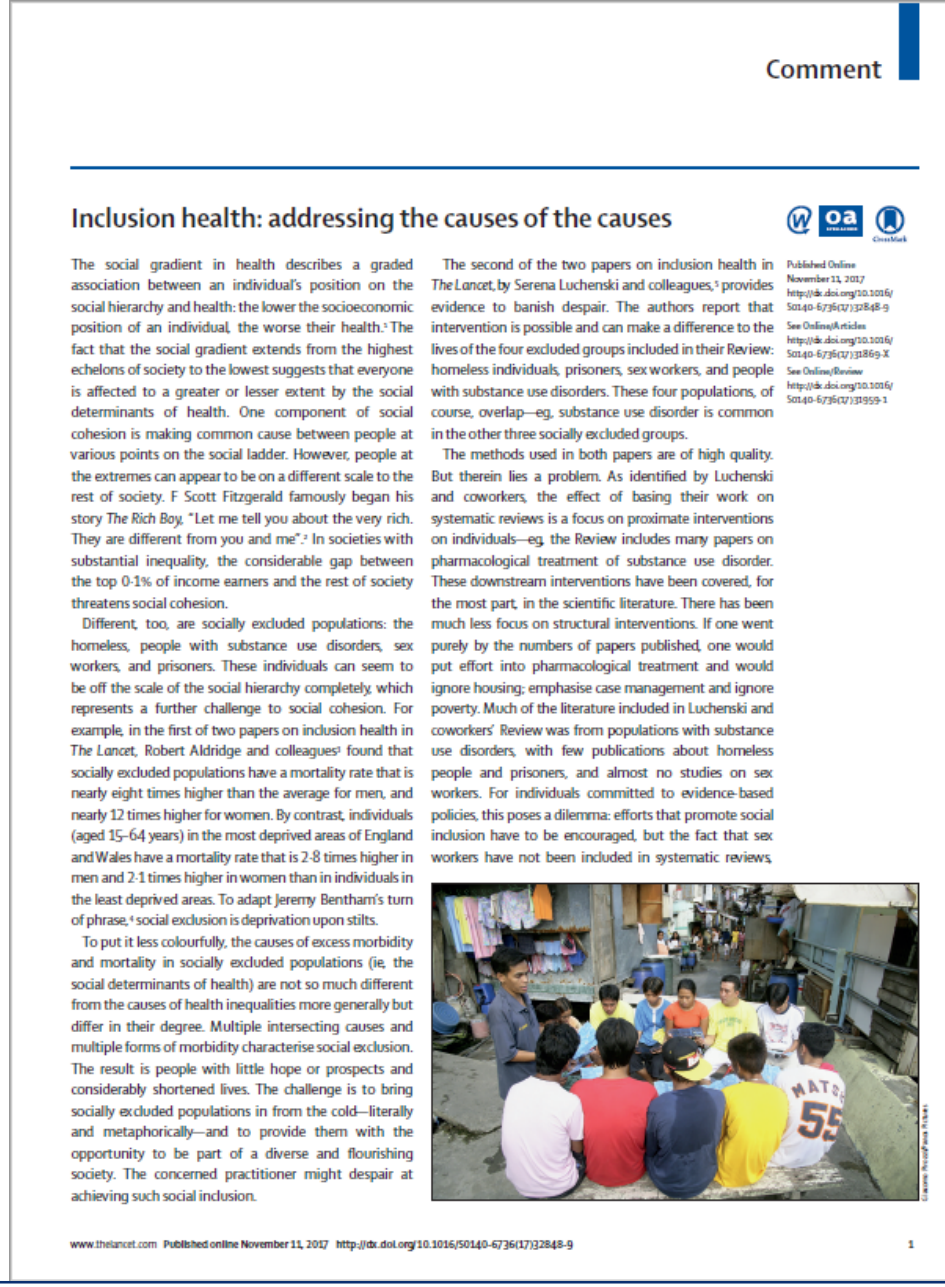
Figure 2. Life expectancy in the bottom income quartile as a function of incarceration rate per 1000 population, lagged 1 year.

Nosrati E, Ash M, Marmot M, McKee M, King LP. The association between income and life expectancy revisited: deindustrialization, incarceration and the widening health gap. Int J Epidemiol. 2018;47(3):720-30.

Whole-of-government problem

"…the causes of excess morbidity and mortality in socially excluded populations (ie, the social determinants of health) are not so much different from the causes of health inequalities more generally but differ in their degree."

"The challenge is to bring socially excluded populations in from the cold—literally and metaphorically—and to provide them with the opportunity to be part of a diverse and flourishing society." Marmot, 2017; p.1.



Comment

Inclusion health: addressing the causes of the causes

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November 11, 2017
http://dx.doi.org/10.1016/S0140-6736(17)32848-9
See Online/Articles
http://dx.doi.org/10.1016/S0140-6736(17)31869-X
See Online/Review
http://dx.doi.org/10.1016/S0140-6736(17)31959-1

The social gradient in health describes a graded association between an individual's position on the social hierarchy and health: the lower the socioeconomic position of an individual, the worse their health.[1] The fact that the social gradient extends from the highest echelons of society to the lowest suggests that everyone is affected to a greater or lesser extent by the social determinants of health. One component of social cohesion is making common cause between people at various points on the social ladder. However, people at the extremes can appear to be on a different scale to the rest of society. F Scott Fitzgerald famously began his story *The Rich Boy*, "Let me tell you about the very rich. They are different from you and me".[2] In societies with substantial inequality, the considerable gap between the top 0·1% of income earners and the rest of society threatens social cohesion.

Different, too, are socially excluded populations: the homeless, people with substance use disorders, sex workers, and prisoners. These individuals can seem to be off the scale of the social hierarchy completely, which represents a further challenge to social cohesion. For example, in the first of two papers on inclusion health in *The Lancet*, Robert Aldridge and colleagues[3] found that socially excluded populations have a mortality rate that is nearly eight times higher than the average for men, and nearly 12 times higher for women. By contrast, individuals (aged 15–64 years) in the most deprived areas of England and Wales have a mortality rate that is 2·8 times higher in men and 2·1 times higher in women than in individuals in the least deprived areas. To adapt Jeremy Bentham's turn of phrase,[4] social exclusion is deprivation upon stilts.

To put it less colourfully, the causes of excess morbidity and mortality in socially excluded populations (ie, the social determinants of health) are not so much different from the causes of health inequalities more generally but differ in their degree. Multiple intersecting causes and multiple forms of morbidity characterise social exclusion. The result is people with little hope or prospects and considerably shortened lives. The challenge is to bring socially excluded populations in from the cold—literally and metaphorically—and to provide them with the opportunity to be part of a diverse and flourishing society. The concerned practitioner might despair at achieving such social inclusion.

The second of the two papers on inclusion health in *The Lancet*, by Serena Luchenski and colleagues,[5] provides evidence to banish despair. The authors report that intervention is possible and can make a difference to the lives of the four excluded groups included in their Review: homeless individuals, prisoners, sex workers, and people with substance use disorders. These four populations, of course, overlap—eg, substance use disorder is common in the other three socially excluded groups.

The methods used in both papers are of high quality. But therein lies a problem. As identified by Luchenski and coworkers, the effect of basing their work on systematic reviews is a focus on proximate interventions on individuals—eg, the Review includes many papers on pharmacological treatment of substance use disorder. These downstream interventions have been covered, for the most part, in the scientific literature. There has been much less focus on structural interventions. If one went purely by the numbers of papers published, one would put effort into pharmacological treatment and would ignore housing; emphasise case management and ignore poverty. Much of the literature included in Luchenski and coworkers' Review was from populations with substance use disorders, with few publications about homeless people and prisoners, and almost no studies on sex workers. For individuals committed to evidence-based policies, this poses a dilemma: efforts that promote social inclusion have to be encouraged, but the fact that sex workers have not been included in systematic reviews,

Marmot M. Inclusion health: addressing the causes of the causes. *The Lancet* 2017; **391**(10117): 186-8.

Thank you for your time!

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